PROCEEDING BEFORE THE HONORABLE MICHAEL D. RILEY
INSURANCE COMMISSIONER OF THE
STATE OF WEST VIRGINIA

IN RE:
THE HEALTH PLAN OF THE UPPER OHIO VALLEY, INC.

ADMINISTRATIVE PROCEEDING NUMBER:
17-MAP-02001

AGREED ORDER ADOPTING REPORT OF MARKET CONDUCT EXAMINATION AND DIRECTING CORRECTIVE ACTION

NOW COMES, The Honorable Michael D. Riley, Insurance Commissioner of the State of West Virginia, and issues this Order which adopts the Report of Market Conduct Examination for the statutory examination of The Health Plan of the Upper Ohio Valley, Inc. ("The Health Plan") for the examination period ending March 31, 2016 based upon the following findings, to wit:

PARTIES

1. The Honorable Michael D. Riley, is the Insurance Commissioner of the State of West Virginia (hereinafter the "Insurance Commissioner") and is charged with the duty of administering and enforcing, among other duties, the provisions of Chapter 33 of the West Virginia Code of 1931, as amended.

2. The Health Plan is a health maintenance organization authorized by the Insurance Commissioner to transact business in the State of West Virginia as permitted and authorized under Article 25A, Chapter 33 of the West Virginia Code.

FINDINGS OF FACT

1. A market conduct examination of the methods of doing business of The Health Plan for the five year period ending March 31, 2016, was conducted in accordance with

West Virginia Code Sections 33-2-9(c) by examiners duly appointed by the Insurance Commissioner.

2. The Statutory Market Conduct Examination included a review of the following mandates:

Guaranteed Availability;

Guaranteed Renewability;

Patient Protections and Essential Health Benefits coverage;

Clinical Trials nondiscrimination;

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA);

Genetic Information Nondiscrimination Act of 2008 (GINA);

Women's Health and Cancer Rights Act of 1998; and

Newborns' and Mothers' Health Protection Act of 1996.

3. A total of seventy (70) standards were tested during this examination; The Health Plan was found to be compliant with sixty-two (62) standards and predominantly compliant with six (6) standards. No standards were found to be non-compliant.

4. The examiners were unable to fully review two (2) standards (C2 Terminated Producers and K2 External Reviews) as there were no producers terminated during the examination period and there were no external reviews conducted since the effective date of W.Va. St. R. 114-97-1.

5. The Health Plan was compliant or predominantly compliant with sixty-eight (68) standards tested, and no standards were found to be non-compliant; however, the examiners cited six (6) recommendations in the standards which are fully set forth in the adopted Report attached hereto.

6. On January 19, 2017, the examiner filed with the Insurance Commissioner, pursuant to West Virginia Code Section 33-2-9(j)(2), a Report of Market Conduct Examination.

7. A true copy of the Report of Market Conduct Examination was sent to The Health Plan.

8. The Health Plan was notified that, pursuant to West Virginia Code 33-2-9(j)(2), it had thirty (30) days after receipt of the Report of Market Conduct Examination to file a submission or objection with the Insurance Commissioner.

9. The Health Plan filed no objections and has elected to enter into this Agreed Order.

10. Any Finding of Fact that is more properly a Conclusion of Law is hereby adopted as such and incorporated in the next section.

CONCLUSIONS OF LAW

1. The Insurance Commissioner has jurisdiction over the subject matter and the parties to this proceeding.

2. This proceeding is pursuant to and in accordance with W.Va. Code §33-2-9.

3. The Insurance Commissioner is charged with the responsibility of verifying continued compliance with West Virginia Code and the West Virginia Code of State Rules by The Health Plan as well as all other provisions of regulation that The Health Plan is subjected to by virtue of their Certificate of Authority to operate in the State of West Virginia.

4. The Health Plan was compliant or predominantly compliant with sixty-eight (68) standards tested, and no standards were found to be non-compliant; however, the

examiners cited six (6) recommendations in the standards which are fully set forth in the adopted Report attached hereto.

5. Any Conclusion of Law that is more properly a Finding of Fact is hereby incorporated as such.

ORDER

Pursuant to West Virginia Code Section 33-2-9(j)(3)(A), following the review of the Report of Market Conduct Examination, the examination work papers, and The Health Plan response thereto, the Insurance Commissioner and The Health Plan have agreed to enter into this Agreed Order adopting the Report of Market Conduct Examination.

It is accordingly **ORDERED** as follows:

(A) The Report of Market Conduct Examination of The Health Plan for the period ending March 31, 2016, is hereby **ADOPTED** and **APPROVED** by the Insurance Commissioner;

(B) It is further **ORDERED** that The Health Plan shall continue to monitor its compliance with state and federal laws applicable to the operation of its business in the State of West Virginia.

(C) It is further **ORDERED** that within thirty (30) days of the next regularly scheduled meeting of its Board of Directors, The Health Plan shall file with the West Virginia Insurance Commissioner, in accordance with West Virginia Code Section 33-2-9(j)(4), affidavits executed by each of its directors stating under oath that they have received a copy of the adopted Report of Market Conduct Examination and a copy of this ORDER ADOPTING REPORT OF MARKET CONDUCT EXAMINATION AND DIRECTING CORRECTIVE ACTION.

(D) It is further **ORDERED** that The Health Plan shall ensure compliance with the West Virginia Code and the Code of State Rules. Specifically, The Health Plan shall follow the recommendations in standards identified in the Report of Market Conduct Examination;

(E) It is further **ORDERED** that **THE HEALTH PLAN SHALL FILE** a Corrective Action Plan which will be subject to the approval of the Insurance Commissioner. The Corrective Action Plan shall address and incorporate all recommendations specifically cited in the Report of Market Conduct Examination by the Insurance Commissioner's examiners. The Corrective Action Plan outlined in this Order must be submitted to the Insurance Commissioner for approval within thirty (30) days of the entry date of this Agreed Order. The Health Plan shall implement reasonable changes to the Corrective Action Plan if requested by the Insurance Commissioner within thirty (30) days of the Insurance Commissioner's receipt of the Corrective Action Plan. The Insurance Commissioner shall provide notice to The Health Plan if the Corrective Action Plan is disapproved and the reasons for such disapproval within thirty (30) days of the Insurance Commissioner's receipt of the Corrective Action Plan;

(F) It is **ORDERED** that The Health Plan shall, within sixty (60) days of this order, forward a copy of this Agreed Order adopting the Report of Market Conduct Examination together with all its appendices to the Chief Market Conduct Examiner of the State of Ohio. The Health Plan shall, within sixty (60) days of this order, offer the State of Ohio, a Corrective Action Plan which addresses the findings contained within the Report of Market Conduct Examination to the extent that the findings and recommendations, if they occurred under the jurisdiction of the State of Ohio, would violate Ohio laws or

regulations; and

(G) It is finally **ORDERED** that all such statutory notices, administrative hearings and appellate rights are herein waived concerning this Report of Market Conduct Examination and Agreed Order. All such rights are preserved by the Parties regarding implementation or further action taken on such Order by the Insurance Commissioner against the The Health Plan of the Upper Ohio Valley, Inc.

Entered this 27th day of January, 2017.

The Honorable Michael D. Riley
Insurance Commissioner
State of West Virginia

REVIEWED AND AGREED TO BY:

On Behalf of the INSURANCE COMMISSIONER:

Jeffrey C. Black, Associate Counsel
Attorney Supervisor

Dated: 1/27/17

On Behalf of The Health Plan of the Upper Ohio Valley, Inc.

By: James M. Pennington
Print Name

Its: President, CEO

Signature:

Date: 1/24/17

Report of Market Conduct Examination

As of March 31, 2016

The Health Plan of the Upper Ohio Valley Inc.

52160 National Road, East
St. Clairsville, OH 43950

NAIC COMPANY CODE: 95677
Examination Number: WV-WV014-2

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January 19, 2017

The Honorable Michael D. Riley
West Virginia Insurance Commissioner
900 Pennsylvania Avenue
Charleston, West Virginia 25302

Dear Commissioner Riley:

Pursuant to your instructions and in accordance with W.Va. Code §33-2-9 and §33-25A-17, an examination has been made as of March 31, 2016 of the business affairs of

The Health Plan of the Upper Ohio Valley Inc.
52160 National Road, East
St. Clairsville, OH 43950

Hereinafter referred to as the "Company" or "The Health Plan". The following report of the findings of this examination is herewith respectfully submitted.

EXECUTIVE SUMMARY

This is the report for the Market Conduct Examination of The Health Plan of the Upper Ohio Valley Inc. (Company or The Health Plan) conducted by the state of West Virginia, under the authorization of W.Va. Code §§33-2-9 and 33-25A-17 and 45 CFR §156.1010. The period covered by the examination was January 1, 2011 through March 31, 2016 with primary focus on the enrollment periods of 2014 and 2015 following the enactment of the Patient Protection and Affordable Care Act of 2010 (PPACA or ACA) as this was the Company's first examination since PPACA was enacted.

The purpose of the examination was to determine the Company's ACA compliance, as well as West Virginia Statutes and Rules. The examination included a review of the following mandates:

- Guaranteed Availability;
- Guaranteed Renewability;
- Patient Protections and Essential Health Benefits coverage;
- Clinical Trials nondiscrimination;
- Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA);
- Genetic Information Nondiscrimination Act of 2008 (GINA);
- Women's Health and Cancer Rights Act of 1998; and,
- Newborns' and Mothers' Health Protection Act of 1996.

The examination commenced on May 16, 2016 and continued through December 6, 2016, with the majority of the work conducted remotely at the West Virginia Offices of the Insurance Commissioner. The examination covered all applicable areas of Chapters XVI, XX, and XXa of the NAIC *Market Regulation Handbook* (including recently adopted ACA standards). Seventy (70) standards were reviewed. The Company was determined to be compliant with sixty-two (62) standards and predominantly compliant with six (6) standards. The examiners were unable to fully review two (2) standards (C2 Terminated Producers and K2 External Reviews) as there were no producers terminated during the examination period and there were no external reviews conducted since the effective date of W. Va. Code R. §114-97-1.

No standards were found to be non-compliant; however, the examiners have the following recommendations in the standards indicated below:

- A7 - Keep a clear record of the producer agent for home office new business.
- G4 - Maintain complaint procedures with the properly required number of days to resolve complaints.
- G6 - Maintain grievance procedures to include sending an acknowledgment letter within the required timeframe and to ensure that grievance responses adhere to the required timeframes.
- G9 - Submit the annual greivance report to the WVOIC as required.
- H3 - Maintain an online Provider Directory that clearly shows when a provider is no longer accepting new patients.

- K1 - Maintain correct wording in the external review procedure to indicate that the IRO is assigned by the WVOIC and not the Company, as well as correctly including the correct number of days for the IRO to provide a decision as forty-five (45) days.

SCOPE OF EXAMINATION

The basic business areas examined were:

- Company Operations/Management
- Complaint Handling/Grievances/Appeals
- Marketing and Sales
- Producer Licensing
- Policyholder Services
- Underwriting and Rating
- Claims
- Utilization Review
- External Review
- Network Adequacy

Each business area has standards that were measured during the examination process. Although most standards have statutory guidance, others are specific to the Company and contractual guidelines.

The focus of the examination was on the methods used by the Company to manage its operations for each of the business areas subject to this examination. Those areas deemed material were tested to determine if the Company is in compliance with West Virginia statutes and rules. The examiners may not have discovered every unacceptable or non-compliant activity in which the Company is engaged. The failure to identify or comment on, or criticize specific Company practices does not constitute an acceptance of the practices by the West Virginia Offices of the Insurance Commissioner.

HISTORY AND PROFILE

The Health Plan of the Upper Ohio Valley, Inc. (The Health Plan) was organized on August 8, 1978 by the issuance of a certificate of incorporation by the Secretary of State of West Virginia, and a certificate of authority by the West Virginia Offices of the Insurance Commissioner (WVOIC) was issued on July 9, 1979 and The Health Plan commenced operations in November, 1979 as a Health Maintenance Organization (HMO). The Health Plan is a not-for-profit, 501-C-4 corporation, chartered in West Virginia, and located in Ohio. The plan is Federally Qualified and holds Certificates of Authority in both West Virginia and Ohio. The Certificates presently encompass all 55 West Virginia counties and a 36 county service area in Ohio. The plan is organized as an IPA type organization and contract both directly with providers and through one (1) organized provider organization. The contracting provider organization is The Upper Ohio Valley Individual Practice Association, Inc. (an IPA representing approximately 280 physicians).

On March 1, 1999 The Health Plan established THP Insurance Co., a wholly–owned subsidiary. This enabled The Health Plan to broaden its product offering capabilities to include PPO and POS fully insured, managed care plans.

The Health Plan employs over four hundred (400) people and maintains offices in four (4) locations throughout its service area: St. Clairsville, OH, Massillon, OH, Morgantown, WV, and Charleston, WV.

The Health Plan, along with it's wholly-owned subsidiary THP, offers a complete line of managed care products and services as follows:

- Fully Insured Health Maintenance Organization (HMO)
- Fully Insured Preferred Provider Organization (PPO)
- Fully Insured Point-of-Service (POS)
- SecureCare (HMO) & SecureChoice (PPO) Medicare Advantage Plans
- Self-Funded Health Plans (EPO, PPO, POS, HMO)
- Proprietary Stop Loss Coverage
- Medicare Supplement coverage
- Dual Eligible product
- Mountain Health Trust/Healthy Bridges – W.V. Medicaid
- Ohio Workers' Compensation Programs
- Self-Funded Workers' Compensation programs
- Complete VEBA Administration and TPA Services
- Consumer Driven products and services
- COBRA Administration

For individual coverage the Company's 2015 West Virginia market share was .072% with written premium of $282,517, providing coverage on fifty-six (56) lives.

For group health coverage the Company's 2015 West Virgina market share was 7.015% with written premium of $72, 234,035, providing coverage on 20,024 lives.

METHODOLOGY

The examination was conducted in accordance with the standards and procedures established by the National Association of Insurance Commissioners (NAIC) and West Virginia's applicable statutes and regulations. The examiners conducted file reviews and interviews of company management. The examination report is a report by test, rather than a report by exception.

Tests designed to measure the level of compliance with all ACA statutes and regulations, along with West Virginia's statutes, rules and regulations were applied to the files selected for review. All standards tested and related results are described this report.

In the results tables, a "pass" response indicates compliance and a "fail" response indicates a failure to comply for each individual file reviewed. The results of each test applied to a sample are reported separately. The examiners used the NAIC standards of 7% error rate on claims test (93% compliance rate) and 10% error rate on all other tests (90% compliance rate) to determine whether or not an apparent pattern or practice of being compliant, predominantly compliant, or non-compliant existed for any given test.

Sampling Methodology – Claims:

The PPACA, federal rule sections 45 CFR §§ 147.150, 147.126, 147.130 and 156.110, requires Issuers to provide benefit coverage for the ten (10) Essential Health Benefits without lifetime or annual limits, and without imposing cost sharing on preventive care services performed by in-network providers. The PPACA also seeks to ensure benefit coverage for individuals participating in approved clinical trials. Additional protections are provided through the mental health and substance abuse parity (MHPAEA), women's health and cancer rights (WHCRA), and newborns' and mothers' protections (NMHPA) laws. Included in these rights, are the non-discrimination requirements related to pre-existing health conditions, dependent coverage up to age 26, genetic testing, and limitations or exclusions due to health status.

Essential Health Benefits (EHBs):

- Ambulatory;
- Hospitalization;
- Prescription drugs (pharmacy);
- Mental health and substance use disorder;
- Preventive care services;
- Pregnancy/maternity;
- Emergency services;
- Laboratory;
- Rehabilitative/Habilitative services; and,
- Pediatric services (dental and vision).

The claims sampling methodology that the examiners chose for this Affordable Care Act (ACA) examination varied from a normal random sampling of paid and denied claims, in order to

determine compliance with the requirements of the PPACA related to the payment of claims within specific benefit categories. Therefore, using ACL, extracts from the primary claims data files provided by the Company were generated utilizing ICD-9 (ICD10) diagnostic codes and CPT codes identified for each of the following categories:

- Ambulatory/hospitalization[1];
- Prescription drugs (pharmacy);
- Mental health and substance abuse (MHPAEA);
- Preventive care services;
- Newborns (NMHPA) and pregnancy/maternity;
- Emergency services;
- Clinical trials;
- Laboratory;
- Pediatric services (dental and vision);
- Women's Health and Cancer Rights Act (WHCRA); and,
- Rehabilitative/Habilitative services

Sample sizes for each of the categories were determined, based on the total population, utilizing the Acceptance Samples Table (AST) found in the NAIC *Market Regulation Handbook*.

The following guidelines were used when reviewing the sample files:

- If, after the review of 25 paid claim files in a sample population, no issues were identified, the review of that sample was terminated.

- If, after the review of 50 denied claim files in a sample population, no issues were identified, the review of that sample was terminated.

Demographic analysis of the claims data was performed to provide an overview of the composition of the claims submitted for payment.

Sampling Methodology – Underwriting Samples:

The underwriting and rating review involved the review of samples for new business, renewals, and cancellations/terminations.

The Company was requested to provide separate data files for the following:

- New Business issued to Individuals;
- Renewal policies for Individuals;
- New Business issued to Small Groups/Small Business Health Options Program.
- Renewal policies for Small Groups.

[1] Since Ambulatory and Hospitalization are such a broad category of Essential Health Benefits (EHB), the review was conducted in the general sample as well as other specific EHB categories.

- Terminations/Cancellations of policies in force more than 90 days; and,
- Applications declined for all markets.

Sample sizes for each of the categories were determined, based on the total population, utilizing the Acceptance Samples Table (AST) found in the NAIC *Market Regulation Handbook*.

A. COMPANY OPERATIONS/MANAGEMENT

The evaluation of standards in the Company operations/management business area is based on a review of Company responses to information requests, questions, interviews, and presentations made to examiners. The review is designed to provide a view of the Company structure and how it operates, and is not based on sampling techniques. The review is not intended to duplicate the management review of a financial examination, but to assist the examiners in gaining a better understanding of the examinee. Many troubled companies have become so because management has not been structured to adequately recognize and address problems that can arise. Well-run companies generally have processes that are similar in structure. While these processes vary in detail and effectiveness from company to company, the absence of the processes or the ineffective application of them often result in failure of various standards tested during an examination. The processes usually include:

- A planning function where direction, policy, objectives, and goals are formulated;
- An execution or implementation of the planning function elements;
- A measurement function that considers the results of the planning and execution; and,
- A reaction function that utilizes the results of measurement activities to take corrective action or to modify the process to develop more efficient and effective management of company operations.

Standard A.1: The regulated entity has an up-to-date, valid internal or external audit program. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 1)

Test Methodology:

- Does the Company have an internal and external audit program to detect structural problems before they occur? [W.Va. Code §§33-33-1, 3 & 4]

Examiner Observations: The examiners reviewed the Company's annual independent service audits, *SSAE 16/SOC 1 Type II Report on Description of Claims Processing System and Third party Administrative Services and the Suitability of Design and Operating Effectiveness of Controls* and their internal audit list performed during the scope of the examination. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard A.2: The regulated entity has appropriate controls, safeguards and procedures for protecting the integrity of computer information. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 2)

Test Methodology:

- Does the Company have appropriate controls, safeguards and procedures for protecting the integrity of computer information? [W.Va. Code R. §114-62-1 et seq.]

Examiner Observations: Documentation reviewed included the Company's *Emergency Response Plan, Record Retention Plan, Corporate Compliance Plan*, as well as training documents provided. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard A.3: The regulated entity has antifraud initiatives in place that are reasonably calculated to detect, prosecute and prevent fraudulent insurance acts. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 3)

Test Methodology:

- Does the Company have an adequate, up-to-date fraud plan in compliance with statutes, rules and regulations? [W. Va. Code §33-41 et seq.]
- Does the Company antifraud plan include procedures for the mandatory reporting of possible fraudulent insurance acts to the insurance commissioner or applicable state regulatory agency pursuant to applicable state statutes, rules and regulations? [W.Va. Code R. §33-41-5]

Examiner Observations: The Company has procedures in place for the mandatory reporting of possible fraudulent insurance acts to the insurance commissioner. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard A.4: The regulated entity has a valid disaster recovery plan. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 4)

Test Methodology:

- Does the Company have a disaster recovery plan that will detail procedures for continuing operations in the event of any type of disaster? [W.Va. Code R. §114-62-1 et seq.]

Examiner Observations: An overview of the Company's disaster recovery plan was reviewed. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard A.5: Contracts between the regulated entity and entities assuming a business function or acting on behalf of the regulated entity, such as but not limited to managing general agents (MGAs), general agents (GAs), third party administrators (TPAs) and management agreements must comply with applicable licensing requirements, statutes, rules and regulations. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 5)

Test Methodology:

- Do the contracts between the Company and entities assuming a business function or acting on behalf of the regulated entity, such as but not limited to managing general agents (MGAs), general agents (GAs), third party administrators (TPAs) and management agreements comply with applicable licensing requirements, statutes, rules and regulations? [W.Va. Code §33-37-2 and W. Va. Code R. §114-53-4]

Examiner Observations: The Company had third party contracts with entities for their pharmacy, vision and dental benefits. All third party entity contracts were reviewed for appropriate licensure requirements; and were reviewed for language specifying the delegated activities and reporting responsibilities, providing for revocation of delegated activities and reporting standards if such parties have not performed satisfactorily, and providing access to records for audit purposes. All contracts were properly executed and included the necessary language or an executed addendum with said language. The company does not utilize MGAs. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard A.6: The regulated entity is adequately monitoring the activities of any entity that contractually assumes a business function or is acting on behalf of the regulated entity. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 6)

Test Methodology:

- Do the Company contracts with third-party entities specify the responsibilities of the MGA, GA and TPA concerning record keeping and responsibilities of the regulated entity for conducting audits? [W.Va. Code §33-37-2 and W. Va. Code R. §114-53-4]
- Does the Company audit the activities of the contracted entities? [W.Va. Code §33-37-4 & Va. Code R. §114-53-4]

Examiner Observations: All third party contracts were determined to specify the recordkeeping responsibilities and the responsibilities of the Company to conduct regular audits. The Company

provided an audit schedule, and the examiners reviewed audits of third party entities conducted during the scope of the examination. Company oversight included, but was not limited to, the Company providing to the third party entities a copy of the Company's Corporate Compliance Plan and Standard of Conduct as well as other company policies, requiring compliance training and providing regulatory guidelines as well as reviewing regulatory agency monitoring, conducting site surveys of providers' offices, monitoring claims for potential abuse and monitoring member complaints and quality issues. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard A.7: Records are adequate, accessible, consistent and orderly and comply with state record retention requirements. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 7)

Test Methodology:

- Does the Company maintain records in compliance with state record retention requirements? [W.Va. Code §§33-2-9, 33-25A-17 and W.Va. Code R. §114-15-4]
- Does the Company adhere to records retention requirements of five (5) years related to grievances/appeals? [W.Va. Code R. §114-96-3]

Examiner Observations: The Company's records retention schedule was reviewed and it was determined to be in compliance with both state and federal retention requirements.

Note: Although individual new business policies were written at the Company physical location by one (1) of only three (3) licensed producers on site, upon review of the policies it was noted that the Heart system, the company's operating system, does not indicate the writing producer, which is not in compliance with W.Va. Code R. §114-15-4.3a.1. (Note: In response to an RFI, the Company was able to provide a list indicating the writing producer and stated that producer information would be included in their Heart system going forward.)

Examiner Recommendations: The Company should ensure compliance in that policy records include the application with a legible means by which an examiner can identify a producer involved in the transaction.

Results: Predominantly Compliant

Standard A.8: The regulated entity is licensed for the lines of business that are being written. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 8)
Test Methodology:

- Does the Company have Certificates of Authority for the lines of business written? [W.Va. Code §33-25A-3]

Examiner Observations: The Company is properly licensed for the lines of business written as required. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard A.9: The regulated entity cooperates on a timely basis with examiners performing the examinations. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 9)

Test Methodology:

- Did the Company provide records on a timely basis? [W.Va. Code §§33-2-9 & 33-25A-17 and W.Va. Code R. §114-15-4.9a]

Examiner Observations: The Company's representatives cooperated in a timely manner with all examiner requests and within the timeframes required by statute. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard A.10: The regulated entity has policies and procedures to protect the privacy of nonpublic personal information relating to its customers, former customers and consumers that are not customers. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 12)

Test Methodology:

- Do the Company policies, practices and procedures regarding protection and disclosure of nonpublic personal information of customers, former customers and consumers who are not customers comply with applicable state laws regarding privacy? [W. Va. Code §§33-2-9 & 33-25A-26 and W.Va. Code R. §§114-57-11 & 114-62-5]

Examiner Observations: The examiners reviewed the *Corporate Compliance Plan* as well as all training materials and numerous individually written policies and procedures as they relate to the protection of nonpublic personal information. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard A.11: The regulated entity provides privacy notices to its customers and, if applicable, to its consumers who are not customers regarding treatment of nonpublic personal financial information. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 13)

Test Methodology:

- Do the Company privacy notices comply with applicable state laws? [W.Va. Code R. §§114-57-2 and 114-57-5]
- Does the Company provide privacy notices timely as required by applicable state laws? [W.Va. Code R. §§114-57-4 and 114-57-8]

Examiner Observations: The examiners confirmed that privacy notices provided to customers and/or non-customers comply with the law, and are sent timely. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard A.12: If the regulated entity discloses information subject to an opt-out right, the regulated entity has policies and procedures in place so that nonpublic personal financial information will not be disclosed when a consumer who is not a customer has opted out, and the regulated entity provides opt-out notices to its customers and other affected consumers. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 14)

Test Methodology:

- Does the Company provide consumers the opportunity to opt out before nonpublic personal information is disclosed? [W.Va. Code R. §114-57-6]
- Does the Company have the capability to keep nonpublic personal financial information from being unlawfully disclosed to nonaffiliated third parties when a consumer has opted out? [W.Va. Code R. §114-57-9]

Examiner Observations: The Company's policy does not allow the disclosure of nonpublic personal financial information to nonaffiliated third parties. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard A.13: The regulated entity's collection, use and disclosure of nonpublic personal financial information are in compliance with applicable statutes, rules and regulations. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 15)

Test Methodology:

- Does the Company comply with regulations regarding disclosing nonpublic personal financial information of its customers or consumers who are not customers to nonaffiliated third parties for joint marketing purposes? [W.Va. Code R. §114-57-11]

Examiner Observations: The Company's policy does not allow the disclosure of nonpublic personal financial information to nonaffiliated third parties. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard A.14: In states promulgating the health information provisions of the NAIC model regulation, or providing equivalent protection through other substantially similar laws under the jurisdiction of the insurance department, the regulated entity has policies and procedures in place so that nonpublic personal health information will not be disclosed, except as permitted by law, unless a customer or a consumer who is not a customer has authorized the disclosure. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 16)

Test Methodology:

- Does the Company obtain valid authorizations from customers and consumers who are not customers before disclosing their nonpublic personal health information, except to the extent such disclosures are permitted? [W.Va. Code R. §114-57-15]

Examiner Observations: The Company's policy does not allow the disclosure of nonpublic personal health information to nonaffiliated third parties. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard A.15: Each Licensee shall implement a written information security program for the protection of nonpublic customer information. . (2015 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 17)

Test Methodology:

- Does the Company have procedures for the security of information? [W.Va. Code R. §114-62-1 et seq.]
- Does the Company have procedures in place to protect the entity's database(s) from various hazards, including environmental? [W.Va. Code R. §114-62-1]

Examiner Observations: The examiners reviewed the *Corporate Compliance Plan* as well as all training materials and numerous individually written policies and procedures as they relate to the protection of nonpublic personal information. The Company has a disaster recovery plan in place to protect its database from various hazards. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

B. MARKETING AND SALES

The review of standards related to the Company's business area of marketing and sales was incorporated within each of the following specific ACA review components:

- Clinical trials;
- Extension of dependent coverage to age 26;
- Guaranteed availability;
- Guaranteed renewability;
- Lifetime/annual benefit limits;
- Prohibitions on preexisting conditions;
- Preventive services.

C. PRODUCER LICENSING

The evaluation of standards is based on the review of the West Virginia Offices of the Insurance Commissioner (WVOIC) records, and the Company responses to information requests, questions, interviews, and presentations made to the examiners. The producer licensing review is designed to test the Company's compliance with state producer licensing laws and rules. A random sample of terminated producers was reviewed to determine compliance with WVOIC statutes and rules. The Company's compliance with licensure and appointment was determined through a random sample of new business policies issued.

Standard C.1: The producers are properly licensed, appointed, and have appropriate continuing education (if required by state law) in the jurisdiction where the application was taken. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §D, Standard 2)

Test Methodology:

- Are Company producer appointments effective within fifteen (15) days of the producer writing business on behalf of the regulated entity? [W.Va. Code §§33-12-1 et seq. and 33-25A-15]

Examiner Observations: The Company's list of current appointed and licensed producers was reconciled with the records of the WVOIC, without exceptions. New business written underwriting samples were reviewed to determine compliance with appointment and licensing regulations and all individual new business was/is produced by agents at the Company site and those, as well as all other agents, were found to be properly licensed and appointed.

Examiner Recommendations: None

Results: Compliant

Table C.1 Results: Producer Appointed Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Individual – New Business	76	76	76	0	90%	100%
Small Group – New Business	434	84	84	0	90%	100%
TOTAL	510	160	160	0	90%	100%

Standard C.2: Records of terminated producers adequately document reasons for terminations. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §D, Standard 5)

Test Methodology:

- Does the Company properly document reasons for producer terminations? [W.Va. Code §33-12-25]
- Does the Company properly report to the insurance department producer terminations for cause? [W.Va. Code §33-12-25]

Examiner Observations: Producer file documentation was reviewed for cause of termination and proper reporting to the WVOIC if applicable. There were no producer terminations for cause during the examination period.

Examiner Recommendations: None

Results: Unable to Review

D. POLICYHOLDER SERVICE

The evaluation of standards related to the Company's business area of policyholder service is based on responses to information requests, questions, interviews, and presentations made to the examiner, and file sampling performed during the examination process. The policyholder service portion of the examination is designed to test the Company's compliance with statutes regarding billing notices and coverage questions.

Standard D.1: Premium notices and billing notices are sent out with an adequate amount of advance notice. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §E, Standard 1)

Test Methodology:

- Does the Company properly handle group renewals in accordance with state guidelines? [W.Va. Code R. §114-54-6]
- Does the Company properly handle individual renewals in accordance with state guidelines? [No direct statutory requirement]

Examiner Observations: The examiner reviewed renewed policies for years 2015 and 2016 to determine compliance with handling and notification requirements. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table D.1 Results: Policyholder Service Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Individual Renewal	26	26	26	0	90%	100%
Small Group Renewals	876	86	86	0	90%	100%
TOTAL	902	112	112	0	90%	100%

Standard D.2: Insured requested cancellations are timely. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §E, Standard 2)

Test Methodology:

- Does the Company handle insured requested cancellations in a timely manner without excessive paperwork requirements for the insured? [W.Va. Code §33-25A-1 et seq.]

Examiner Observations: The examiner reviewed a sample of cancelled/terminated policies to determine whether insured requested cancellations were handled timely and without excessive paperwork. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table D.2 Results: Cancelled/Terminated Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Cancelled/Terminated Policies	377	84	84	0	90%	100%
TOTAL	377	84	84	0	90%	100%

Standard D.3: All correspondence directed to the regulated entity is answered in a timely and responsive manner by the appropriate department. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §E, Standard 3)

Test Methodology:

- Does the correspondence in the policy files show the Company response was appropriate and timely handled? [W.Va. Code §33-25A-1 et seq. and W.Va. Code R. §114-14-5]

Examiner Observations: No correspondence was determined to be inappropriate.

Examiner Recommendations: No exceptions were noted.

Results: Compliant

Standard D.4: A health carrier shall make a summary of benefits and coverage available in compliance with final regulations issued by the federal Department of Health and Human Services (HHS), Department of Labor (DOL) and the Treasury.
(2015 NAIC *Market Regulation Handbook*, Chapter 20A, §J, Standard 2)

Test Methodology:

- Does the Company make the Summary of Benefits and Coverage and Uniform Glossary available without cost to consumers, when "shopping," upon application for insurance, or during a plan or policy year? [45 CFR §147.200]

Examiner Observations: The examiner verified that the current Summary of Benefits and Coverage (SBC) are provided upon application and renewal. Additionally, the Company makes the documents available on its website, where individuals are not required to have a login in order to access the SBC. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

E. UNDERWRITING AND RATING

The evaluation of standards for the business area related to the Company's underwriting and rating practices were based on responses to information requests, questions, interviews, presentations made to the examiner, and file sample reviews. The application process under Healthcare Reform no longer involves medical underwriting. However, the underwriting and rating practices portion of this examination is designed to verify how the Company treats the public, and whether that treatment is in compliance with applicable statutes, rules and regulations. It is typically determined by testing a random sampling of files and applying various tests to the sampled files. Samples were taken from the population of new business policies issued. In general, declinations and cancellations/terminations were reviewed under the Health Reform standards of guaranteed availability and guaranteed renewability. Policy form and rate filings were not reviewed, but accepted as in compliance based on prior WVOIC filing and approval.

Standard E.1: The rates charged for the policy coverage are in accordance with filed rates (if applicable) or the regulated entity's rating plan. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §F, Standard 1)

Test Methodology:

- Do the premium rates charged match the premium rates that were filed and approved? [W.Va. Code §§33-25A-3(l), 33-25A-8(2) and 33-25A-24]

Examiner Observations: Examiners reviewed the new business underwritten to verify the rates charged were the same as those filed and approved by the WVOIC.

Note: The Company filed rates did not match the rates used during this review. The Company agreed that it was an issue in the amount of decimal places used for the Base Rate and the Calibration Factor to compute the Rates in the Rate Tables submitted by the actuaries for the Unified Rate Review Template (URRT) for rate filings. The discrepancy was de minimis and as such was determined to not be a violation.

Examiner Recommendations: None

Results: Compliant

Table E.1 Results: Underwriting Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Individual – New Business	76	76	76	0	90%	100%
Small Group – New Business	434	84	84	0	90%	100%
TOTAL	510	160	160	0	90%	100%

Standard E.2: All mandated disclosures are documented and in accordance with applicable statutes, rules and regulations. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §F, Standard 2)

Test Methodology:

- Does the Company provide an annual notification to individuals regarding the availability of WHCRA benefits? [W. Va. Code §33-25A-17 and 42 U.S.C. §300gg-52]
- Does the Company provide internal and external appeals notices as required? [W. Va. Code §33-25A-17 and 45 CFR §147.136]
- Does the Company prominently post rate change justification on their website? [W. Va. Code §33-25A-17 and 45 CFR §156.210]
- Does the Company provide notification for group health plans of the election of mental health/substance use disorder coverage? [W. Va. Code §33-25A-17 and 42 U.S.C. §300gg-26]

Examiner Observations: The examiner reviewed the Company's practices regarding providing of all mandated notifications through review of a sample of renewal policies during the scope of the examination. The Company provides the consumers' disclosures concomitantly with Summary of Benefits on basic renewals and keeps an electronic record in the *Heart* system that indicates which forms and form versions were issued for each term of the policy. The company provides all required notifications. No exceptions were noted.

Examiner Recommendations: None.

Results: Compliant

Table E.2 Results: Mandated Notification Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Individual Renewal	26	26	26	0	90%	100%
Small Group Renewals	876	86	86	0	90%	100%
TOTAL	902	112	112	0	90%	100%

Standard E.3: The regulated entity complies with the Genetic Information Nondiscrimination Act of 2008. (2015 NAIC *Market Regulation Handbook*, Chapter 20, §F, Standard 4)

Test Methodology:

- Does the Company comply with the requirements of GINA, which prohibits group health plans and health insurance issuers from discriminating based on genetic information? [45 CFR §146.122(b) and 45 CFR §148.180(b)(1)]

Examiner Observations: The examiners reviewed an underwriting sample of new business to determine whether discrimination was applied in the issuing of policies based on genetic information. The Company does not ask for genetic information. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table E.3 Results: Underwriting Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Individual – New Business	76	76	76	0	90%	100%
Small Group – New Business	434	84	84	0	90%	100%
TOTAL	510	160	160	0	90%	100%

Standard E.4: All forms, including policies, contracts, riders, amendments, endorsement forms and certificates are filed with the insurance department, if applicable. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §F, Standard 5)

Test Methodology:

- Did the Company use forms and endorsements that were filed and approved by the WVOIC? [W.Va. Code §33-6-8, 33-25A-3 and 33-25A-8]

Examiner Observations: The review of Company filing documentation confirmed the Company was using forms, which were filed and approved by the WVOIC. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard E.5: A health carrier may not deny coverage or restrict coverage for qualified individuals, as defined in applicable statutes, rules and regulations, who participate in approved clinical trials. (2015 NAIC *Market Regulation Handbook*, Chapter 20A, §A, Standard 1)

Test Methodology:

- Does the Company have established and implemented underwriting policies and procedures regarding the prohibition of denial and restriction of coverage for qualified individuals participating in approved clinical trials in accordance with statute and regulatory guidance established by HHS, DOL and the Treasury?
- Does the Company deny participation by a qualified individual in an approved clinical trial? [W.Va. Code §33-25F-2(c) and (d) and 42 U.S.C. §300gg-8]
- Do marketing materials provided to insureds and prospective purchasers by the Company provide complete and accurate information about coverage for individuals participating in approved clinical trials? [45 CFR §156.225(b)]

Examiner Observations: The examiner reviewed all unique denied clinical trials and a sample of paid clinical trials. It was determined that no covered persons were discriminated against or denied coverage based on participation in clinical trials. The marketing and training materials used by the Company provided complete and accurate information. No exceptions were noted. (See Also Standard F7)

Examiner Recommendations: None

Results: Compliant

Standard E.6: A group health plan, or a health carrier offering group or individual health insurance coverage, that makes available dependent coverage of children shall make such coverage available for children until attainment of 26 years of age. (2015 NAIC *Market Regulation Handbook*, Chapter 20A, §B, Standard 1)

Test Methodology:

- Does the Company have established and implemented underwriting policies and procedures related to extension of dependent coverage for individuals to age 26 in compliance with final regulations established by HHS, DOL and the Treasury?
- Do the plan benefits vary based upon age, except for dependent children who are 26 years of age or older? [45 CFR §147.120(b)]
- Does the health carrier provide a dependent child whose coverage ended with at least a 30-day written notice of the opportunity to enroll in a health benefit plan? [45 CFR §147.120(f)]
- Does the Company treat a dependent child enrolling in group health insurance coverage as a special enrollee, as provided under final regulations established by HHS, DOL and Treasury? [45 CFR §147.120(f) and 45 CFR §146.117(d)]
- Does the Company maintain proper documentation for correspondence, including website notifications, supporting corrective action provided to dependent child for whom coverage was inappropriately cancelled or denied? [W.Va. Code R. §114-15-4.2]
- Were the policy forms filed and approved by the state for use? [W.Va. Code §§33-6-8, 33-25A-3 and 33-25A-8]
- Do marketing materials provided to insureds and prospective purchasers by the Company provide complete and accurate information about extension of coverage for dependents to age 26? [45 CFR §156.225(b)]

Examiner Observations: A review of the underwriting procedures showed that no guidelines were in place to deny the extension of coverage to dependents to age 26, or vary plan benefits based on dependents age. Procedures are in place for the required 30-day notification. All policy forms were filed and approved by the WVOIC. Marketing materials were found to provide complete and accurate information. No exceptions were noted.

Examiner Recommendations: None
Results: Compliant

Table E.6 Results: Dependent Coverage Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Individual – New Business	76	76	76	0	90%	100%
Small Group – New Business	434	84	84	0	90%	100%
TOTAL	510	160	160	0	90%	100%

Standard E.7: A health carrier offering individual market health insurance coverage shall issue any applicable health benefit plan to any eligible individual who: 1) applies for the plan; 2) agrees to make the required premium payments; and 3) agrees to satisfy the other reasonable provisions of the health benefit plan that are not inconsistent with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury). (2015 NAIC *Market Regulation Handbook*, Chapter 20A, §D, Standard 1)

Test Methodology:

- Do the Company underwriting practices related to guaranteed availability provide adequate and appropriate processes to ensure the health carrier makes individual market health insurance coverage available on a guaranteed availability basis to eligible plan applicants in compliance with final regulations established by HHS, DOL and the Treasury? [W.Va. Code §33-15-2b and 45 CFR §147.104(a)]
- Do the Company complaint register/logs and complaint files identify complaints pertaining to restriction of guaranteed availability of coverage? [W.Va. Code §33-15-2b and 45 CFR §147.104(a)]
- Does the Company maintain proper documentation for correspondence, including website notifications, supporting corrective action provided to an eligible plan applicant who was not offered health insurance coverage on a guaranteed availability basis? [W.Va. Code R. §114-15-4.2]
- Do the Company marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about guaranteed availability of individual market health insurance coverage? [45 CFR §156.225]

Examiner Observations: All underwriting guidelines were determined to be in compliance with regulations. All files were properly documented. All marketing materials provided complete and accurate information. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table E.7 Results: Guaranteed Availability Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Individual – New Business	79	79	79	0	90%	100%

Standard E.8 A health carrier offering small group market health insurance coverage shall issue any applicable health benefit plan to any eligible small group employer that: 1) applies for the plan; 2) agrees to make the required premium payments; and 3) agrees to satisfy the other reasonable provisions of the health benefit plan that are not inconsistent with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury). (2015 NAIC *Market Regulation Handbook*, Chapter 20A, §D, Standard 2)

Test Methodology:

- Do the Company underwriting practices related to guaranteed availability provide adequate and appropriate processes to ensure the health carrier makes small group market health insurance coverage available on a guaranteed availability basis to eligible small employers in compliance with final regulations established by HHS, DOL and the Treasury? [W.Va. Code §114-54-9 and 45 CFR §§146.150(a) and 147.104(a)]
- Do the Company procedures prohibit any waiting period that exceeds 90 days? [45 CFR §147.116]
- Does the Company require participation levels greater than: 100% of eligible employees working for groups of 3 or fewer employees; and, 75% of eligible employees working for groups with more than 3 employees? [W.Va. Code R. §114-54-9.4]
- Do the Company complaint register/logs and complaint files identify complaints pertaining to restriction of guaranteed availability of coverage? [W.Va. Code R. §114-54-9 and 45 CFR §§146.150(a) and 147.104(a)]
- Does the Company maintain proper documentation for correspondence, including website notifications, supporting corrective action provided to an eligible small employer who was not offered health insurance coverage on a guaranteed availability basis? [W.Va. Code R. §114-15-4.2]
- Do the Company marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about guaranteed availability of small group market health insurance coverage? [45 CFR §156.225]

Examiner Observations: All underwriting guidelines were determined to be in compliance with regulations. All files were properly documented. All marketing materials provided complete and accurate information. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table E.8 Results: Guaranteed Availability Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Small Group – New Business	434	84	84	0	90%	100%

Standard E.9: A health carrier offering individual market health insurance coverage shall renew or continue in force the coverage, at the option of the policyholder, subject to final

regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury). (2015 NAIC *Market Regulation Handbook*, Chapter 20A, §E, Standard 1)

Test Methodology:

- Do the Company underwriting practices related to guaranteed renewability provide adequate and appropriate processes to ensure the health carrier renews, or continues in force, at the option of the policyholder, individual market health insurance coverage, in compliance with final regulations established by HHS, DOL and the Treasury? [W.Va. Code R. §114-54-6 and 45 CFR §147.106]
- Do the Company underwriting practices ensure that nonrenewal or discontinuance of coverage of a health benefit plan is performed only as defined by applicable statutes and rules? [W.Va. Code R. §114-54-6 and 45 CFR §147.106]
- Do the Company complaint register/logs and complaint files identify complaints pertaining to restriction of guaranteed renewability of coverage? [W.Va. Code R. §114-54-6 and 45 CFR §147.106]
- Does the Company maintain proper documentation for correspondence, including website notifications, supporting corrective action provided to an eligible plan applicant who was not offered health insurance coverage on a guaranteed availability basis? [W.Va. Code R. §114-15-4.2]
- Do the Company marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about guaranteed renewability of individual market health insurance coverage? [45 CFR §156.225]

Examiner Observations: All underwriting guidelines were determined to be in compliance with regulations. A review of complaints identified none related to denial of renewal coverage. All files were properly documented. All marketing materials provided complete and accurate information. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table E.9 Results: Guaranteed Renewability Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Individual – Renewals	26	26	26	0	90%	100%

Standard E.10: A health carrier offering small group market health insurance coverage shall renew or continue in force the coverage, at the option of the small employer subject to final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury). (2015 NAIC *Market Regulation Handbook*, Chapter 20A, §E, Standard 2)

Test Methodology:

- Do the Company underwriting practices related to guaranteed renewability provide adequate and appropriate processes to ensure the health carrier renews, or continues in force, at the option of the small employer, small group market health insurance coverage, in compliance with final regulations established by HHS, DOL and the Treasury? [W.Va. Code R. §114-54-6 and 45 CFR §146.152(a)]
- Do the Company underwriting practices ensure that nonrenewal or discontinuance of coverage of a health benefit plan is performed only as defined by applicable statutes and rules? [W.Va. Code R. §114-54-6 and 45 CFR §146.152(b)]
- Do the Company complaint register/logs and complaint files identify complaints pertaining to restriction of guaranteed renewability of coverage? [W.Va. Code R. §114-54-6 and 45 CFR §147.106(a)]
- Does the Company maintain proper documentation for correspondence, including website notifications, supporting corrective action provided to a policyholder whose health benefit plan providing small group market health insurance coverage was non-renewed or discontinued? [W.Va. Code R. §114-15-4.2]
- Do the Company marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about guaranteed renewability of small group market health insurance coverage? [45 CFR §156.225]

Examiner Observations: All underwriting guidelines were determined to be in compliance with regulations. A review of complaints identified none related to denial of renewal coverage. All files were properly documented. All marketing materials provided complete and accurate information. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table E.10 Results: Guaranteed Renewability Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Small Group – Renewals	876	86	86	0	90%	100%

Standard E.11: A health carrier may not deny coverage to applicants/proposed insureds pursuant to the provisions of any preexisting condition exclusion or preexisting condition limitation. (2015 NAIC *Market Regulation Handbook*, Chapter 20A, §G, Standard 1)

Test Methodology:

- Does the Company limit or exclude coverage under an individual or group health insurance benefit plan for an individual via the health carrier's issuance of a preexisting condition exclusion on that individual? [W.Va. Code §33-6-8 and 45 CFR §147.108]
- Do the Company grievance/complaint records identify inquiries regarding coverage denials for applicants/proposed insureds on the basis of a preexisting condition? [W.Va. Code §33-6-8 and 45 CFR §147.108]

- Does the Company that only covers individuals, offer such coverage continuously throughout the year, or during one or more open enrollment periods as set forth in applicable state statutes, rules and regulations?

Examiner Observations: All underwriting guidelines were determined to be in compliance with regulations. A review of complaints identified none related to denial of coverage due to preexisting conditions. All files were properly documented. All marketing materials provided complete and accurate information. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard E.12: Policy language, enrollment materials and marketing and sales materials may not directly or indirectly indicate that individuals with a preexisting condition cannot enroll in coverage or receive benefits under a group health or individual health insurance policy. (2015 NAIC *Market Regulation Handbook*, Chapter 20A, §G, Standard 3)

Test Methodology:

- Do the Company's filed policy forms and endorsements contain limitations or exclusions for preexisting conditions applicable to individuals? [W.Va. Code §33-6-8]
- Do the Company's enrollment materials, marketing and sales materials and other information disseminated to applicants/proposed insureds, insureds and claimants provide complete and accurate information about the limitations and restrictions regarding the issuance of preexisting condition exclusions limitations on individuals? [45 CFR §155.225]

Examiner Observations: A review of marketing and training materials were determined to be accurate and not misleading regarding the issue of preexisting condition limitations or exclusions. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard E.13: A health carrier may not retrospectively rescind individual or group coverage (including family coverage in which the individual is included) unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact. (2015 NAIC *Market Regulation Handbook*, Chapter 20A, §I, Standard 1)

Test Methodology:

- Does the Company rescind policies inappropriately? [W. Va. Code §33-3-11 and 45 CFR §147.128]
- Does the Company take appropriate corrective action/adjustments regarding the reinstatement of coverage in a timely and accurate manner on the insured's policy when coverage has been rescinded inappropriately? [W. Va. Code §33-3-11 and 45 CFR §147.128]
- Does the Company maintain proper documentation for all correspondence supporting corrective action provided to the insured, including website notifications? [W.Va. Code R. §114-15-4.2]

Examiner Observations: The Company stated that it had not rescinded any policies during the scope of the examination. A memorandum of attestation was provided. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard E.14: A health carrier offering group or individual health insurance coverage shall provide at least 30 days' advance written notice to each plan enrollee (in the individual market, primary subscriber) who would be affected before coverage may be rescinded. (2015 NAIC *Market Regulation Handbook*, Chapter 20A, §I, Standard 2)

Test Methodology:

- Does the Company provide the required 30-day advance written notice to a plan enrollee, or, in the individual market, a primary subscriber? [W. Va. Code §33-3-11 and 45 CFR §147.128]
- Does the Company maintain proper documentation for all correspondence supporting corrective action provided to the insured, including website notifications? [W.Va. Code R. §114-15-4.2]

Examiner Observations: The policy form contains language indicating that 30 days' notice will be provided in the event of rescission. As indicated above the Company stated that it had not rescinded any policies during the scope of the examination.

Examiner Recommendations: None

Results: Compliant

F. CLAIMS

The evaluation of standards related to the claims business area is based on Company responses to information requested by the examiner, discussions with company staff, electronic testing of claim databases, and file sampling during the examination process. The claims portion of the examination is designed to provide a view of how the Company treats claimants, and whether that treatment is in compliance with applicable statutes and rules. As stated under the Methodology section, the claims samples were specifically selected to verify compliance with the ACA mandated service requirements.

Therefore, using ACL, randomly selected extracts from the primary claims data files provided by the Company were generated utilizing ICD-9 (ICD 10) diagnostic codes and CPT codes identified for each of the following categories:

- Prescription drugs (pharmacy);
- Mental health and substance abuse (MHPAEA);
- Preventive care services;
- Newborns (NMHPA) and pregnancy/maternity;
- Emergency services;
- Clinical trials;
- Laboratory;
- Pediatric services (dental and vision);
- Women's Health and Cancer Rights Act (WHCRA); and,
- Rehabilitative/Habilitative services.

Sample Variances: In some cases samples were taken from Essential Health Benefits (EHB) compliant plans only and some samples were taken from both compliant and non-compliant EHB plans. Accordingly, all samples were for the service date of January 1, 2014 forward. Since it was decided at the start of the examination that, if no issues were found, examiners would limit the reviews to only 25 paid claims and 50 denied claims in each category, the tables associated with each procedure below reflect the number of actual claims reviewed in the sample set. If the total population was not enough for the sample amount, the entire population was reviewed. Due to the lack of direct access of pharmacy claims data, only twenty-five (25) denied claims were reviewed.

Standard F.1: Claim files are handled in accordance with policy provisions, HIPAA and state law. (2015 NAIC *Market Regulation Handbook*, Chapter 20, §G, Standard 1)

Test Methodology:

- Does the Company have procedures, training manual, and claim bulletins in place for the proper handling of claims in a fair and nondiscriminatory manner? [W.Va. Code §33-11-4(9)(c)]

- Does the Company have procedures for the detection and reporting of fraudulent or potentially fraudulent insurance acts and proper referral of suspicious claims? [W.Va. Code §§33-41-3 and 5]
- Does the Company handle claims in accordance with policy provisions? [W.Va. Code §33-45-2 and 45 CFR §156.110]

Examiner Observations: The examiners reviewed the Company procedures for claims processing, the Company Anti-Fraud manual, and claims handling in accordance with plan benefits. There were no exceptions.

Examiner Recommendations: None.

Results: Compliant

Table F.1.a Results: Paid Claims Sample

Type	Total Population	Paid Sample	Pass	Fail	Standard	Compliance
General Claims	17,115,153	26	26	0	93%	100%
Emergency Services	134,824	25	25	0	93%	100%
Rehabilitative/Habilitative Services	9,024	25	25	0	93%	100%
Preventive/Wellness Services	85	85	85	0	93%	100%
Prescription Drugs/Pharmacy	1,620,548	25	25	0	93%	100%
Mental Health/Substance Abuse Services	26,925	25	25	0	93%	100%
Pediatric Services	17	17	17	0	93%	100%
Laboratory Services	40,826	25	25	0	93%	100%
Pregnancy/Maternity/Newborn Care	12,760	25	25	0	93%	100%
Clinical Trials	4	4	4	0	93%	100%
WHCRA	677	25	25	0	93%	100%
TOTAL	18,960,843	307	307	0	93%	100%

Table F.1.b Results: Denied Claims Sample

Type	Total Population	Denied Sample	Pass	Fail	Standard	Compliance
General Claims	235,210	50	50	0	93%	100%
Emergency Services	48,202	50	50	0	93%	100%
Rehabilitative/Habilitative Services	3	3	3	0	93%	100%
Preventive/Wellness Services	24	24	24	0	93%	100%
Prescription Drugs/Pharmacy	24,397	25	25	0	93%	100%
Mental Health/Substance Abuse Services	6,483	50	50	0	93%	100%
Pediatric Services	15	15	15	0	93%	100%
Laboratory Services	16,121	50	50	0	93%	100%

Type	Total Population	Denied Sample	Pass	Fail	Standard	Compliance
Pregnancy/Maternity/Newborn Care	82,636	50	50	0	93%	100%
Clinical Trials	5	5	5	0	93%	100%
WHCRA	1	1	1	0	93%	100%
TOTAL	413,097	471	471	0	93%	100%

Standard F.2: The company complies with the requirements of the federal Newborns' and Mothers' Health Protection Act of 1996. (2015 NAIC *Market Regulation Handbook*, Chapter 20, §G, Standard 2)

Test Methodology:

- Does the Company comply with the standards of the NMHPA with regard to 48/96 hour minimums? [45 CFR §146.130]
- Does the Company engage in incentive arrangements to circumvent the requirements of the law? [45 CFR §146.130]

Examiner Observations: A sample of claims related to maternity and newborn benefits were reviewed. The Company complies with the 48/96 minimum standard, and did not engage in incentives to circumvent the requirements of the law. No issues were noted.

Examiner Recommendations: None

Results: Compliant

Table F.2.a Results: NMHPA Paid Claims Sample

Type	Total Population	Paid Sample	Pass	Fail	Standard	Compliance
Pregnancy/Maternity/Newborn Care	12,760	25	25	0	93%	100%

Table F.2.b Results: NMHPA Denied Claims Sample

Type	Total Population	Denied Sample	Pass	Fail	Standard	Compliance
Pregnancy/Maternity/Newborn Care	82,636	50	50	0	93%	100%

Standard F.3: Claims are resolved in a timely manner. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §G, Standard 3)

Test Methodology:

- Does the Company resolve claims in accordance with state requirements? [W.Va. Code R. §114-14-6]

Examiner Observations: Time studies on the claim samples determined that all claims were paid in compliance with state requirements. No exceptions were noted.
Examiner Recommendations: None

Results: Compliant

Table F.3.a Results: Paid Claims Sample

Type	Total Population	Paid Sample	Pass	Fail	Standard	Compliance
General Claims	17,115,153	26	26	0	93%	100%
Emergency Services	134,824	25	25	0	93%	100%
Rehabilitative/Habilitative Services	9,024	25	25	0	93%	100%
Preventive/Wellness Services	85	85	85	0	93%	100%
Prescription Drugs/Pharmacy	1,620,548	25	25	0	93%	100%
Mental Health/Substance Abuse Services	26,925	25	25	0	93%	100%
Pediatric Services	17	17	17	0	93%	100%
Laboratory Services	40,826	25	25	0	93%	100%
Pregnancy/Maternity/Newborn Care	12,760	25	25	0	93%	100%
Clinical Trials	4	4	4	0	93%	100%
WHCRA	677	25	25	0	93%	100%
TOTAL	18,960,843	307	307	0	93%	100%

Table F.3.b Results: Denied Claims Sample

Type	Total Population	Denied Sample	Pass	Fail	Standard	Compliance
General Claims	235,210	50	50	0	93%	100%
Emergency Services	48,202	50	50	0	93%	100%
Rehabilitative/Habilitative Services	3	3	3	0	93%	100%
Preventive/Wellness Services	24	24	24	0	93%	100%
Prescription Drugs/Pharmacy	24,397	25	25	0	93%	100%
Mental Health/Substance Abuse Services	6,483	50	50	0	93%	100%
Pediatric Services	15	15	15	0	93%	100%
Laboratory Services	16,121	50	50	0	93%	100%
Pregnancy/Maternity/Newborn Care	82,636	50	50	0	93%	100%
Clinical Trials	5	5	5	0	93%	100%
WHCRA	1	1	1	0	93%	100%
TOTAL	413,097	323	323	0	93%	100%

Standard F.4: The group health plan complies with the requirements of the federal Mental Health Parity Act of 1996 (MHPA) and the revisions made in the Mental Health Parity and Addiction Equity Act of 2008. (2015 NAIC *Market Regulation Handbook*, Chapter 20, §G, Standard 3)

Test Methodology:

- Does the group health plan comply with the requirements of the federal Mental Health Parity Act of 1996 (MHPA) and the revisions made in the Mental Health Parity and Addiction Equity Act of 2008? [45 CFR §146.136]

Examiner Observations: The examiners reviewed the claim samples to determine if the claims for mental health and substance abuse were paid in accordance with the parity requirements provided under the law and without additional requirements relative to authorizations. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table F.4.a Results: MHPAEA Paid Claims Sample

Type	Total Population	Paid Sample	Pass	Fail	Standard	Compliance
Mental Health/Substance Abuse Services	26,925	25	25	0	93%	100%

Table F.4.b Results: MHPAEA Denied Claims Sample

Type	Total Population	Denied Sample	Pass	Fail	Standard	Compliance
Mental Health/Substance Abuse Services	6,483	50	50	0	93%	100%

Standard F.5: The group health plan complies with the requirements of the federal Women's Health and Cancer Rights Act of 2008. (2015 NAIC *Market Regulation Handbook*, Chapter 20, §G, Standard 4)

Test Methodology:

- Does the Company provide mastectomy-related reconstruction coverage as required by law? [42 U.S.C. §300gg-52 and 29 U.S.C. §1185b]

Examiner Observations: A sample of claims related to reconstructive surgery and prosthetic treatments or devices was reviewed to determine compliance under WHCRA. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table F.5.a Results: WHCRA Paid Claims Sample

Type	Total Population	Paid Sample	Pass	Fail	Standard	Compliance
WHCRA	677	25	25	0	93%	100%

Table F.5.b Results: WHCRA Denied Claims Sample

Type	Total Population	Denied Sample	Pass	Fail	Standard	Compliance
WHCRA	1	1	1	0	93%	100%

Standard F.6: Claim files are adequately documented. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §G, Standard 5)

Test Methodology:

- Does the Company adequately document all claim files? [W.Va. Code R. §114-14-3]
- Does the Company maintain claim file documentation in accordance with state retention requirements? [W. Va. Code R. §114-15-4]

Examiner Observations: Review of the claim files determined that all were adequately documented. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table F.6.a Results: Paid Claims Sample

Type	Total Population	Paid Sample	Pass	Fail	Standard	Compliance
General Claims	17,115,153	26	26	0	93%	100%
Emergency Services	134,824	25	25	0	93%	100%
Rehabilitative/Habilitative Services	9,024	25	25	0	93%	100%
Preventive/Wellness Services	85	85	85	0	93%	100%
Prescription Drugs/Pharmacy	1,620,548	25	25	0	93%	100%
Mental Health/Substance Abuse Services	26,925	25	25	0	93%	100%
Pediatric Services	17	17	17	0	93%	100%

Type	Total Population	Paid Sample	Pass	Fail	Standard	Compliance
Laboratory Services	40,826	25	25	0	93%	100%
Pregnancy/Maternity/Newborn Care	12,760	25	25	0	93%	100%
Clinical Trials	4	4	4	0	93%	100%
WHCRA	677	25	25	0	93%	100%
TOTAL	18,960,843	307	307	0	93%	100%

Table F.6.b Results: Denied Claims Sample

Type	Total Population	Denied Sample	Pass	Fail	Standard	Compliance
General Claims	235,210	50	50	0	93%	100%
Emergency Services	48,202	50	50	0	93%	100%
Rehabilitative/Habilitative Services	3	3	3	0	93%	100%
Preventive/Wellness Services	24	24	24	0	93%	100%
Prescription Drugs/Pharmacy	24,397	25	25	0	93%	100%
Mental Health/Substance Abuse Services	6,483	50	50	0	93%	100%
Pediatric Services	15	15	15	0	93%	100%
Laboratory Services	16,121	50	50	0	93%	100%
Pregnancy/Maternity/Newborn Care	82,636	50	50	0	93%	100%
Clinical Trials	5	5	5	0	93%	100%
WHCRA	1	1	1	0	93%	100%
TOTAL	413,097	323	323	0	93%	100%

Standard F.7: A health carrier may not deny coverage or restrict coverage for qualified individuals, as defined in applicable statutes, rules and regulations, who participate in approved clinical trials. (2015 NAIC *Market Regulation Handbook*, Chapter 20A, §A, Standard 1)

Test Methodology:

- Does the Company deny, limit or impose additional conditions on the coverage of routine patient costs for items or services furnished in connection with participation in a trial? [W.Va. Code §§33-25F-2(c)(1) and (2) and 42 U.S.C. §300gg-8)]
- Does the Company maintain proper documentation for correspondence, including website notifications, supporting corrective action provided to an individual for whom coverage for participation in an approved clinical trial was inappropriately restricted or denied? [W.Va. Code R. §114-15-4.2]

Examiner Observations: The examiner reviewed all unique denied clinical trials and all paid clinical trials. It was determined that no covered persons were discriminated against or denied coverage based on participation in clinical trials. All claims were paid in accordance with the plans

schedule of benefits. The marketing and training materials used by the Company provided complete and accurate information. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table F.7.a Results: Clinical Trials Paid Claims Sample

Type	Total Population	Paid Sample	Pass	Fail	Standard	Compliance
Clinical Trials	4	4	4	0	93%	100%

Table F.7.b Results: Clinical Trials Denied Claims Sample

Type	Total Population	Denied Sample	Pass	Fail	Standard	Compliance
Clinical Trials	5	5	5	0	93%	100%

Standard F.8: A health carrier shall not establish any lifetime or annual limit on the dollar amount of essential health benefits (EHB)s for any individual, in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury). (2015 NAIC *Market Regulation Handbook*, Chapter 20A, §F, Standard 1)

Test Methodology:

- Does the Company apply lifetime/annual limits on the dollar amount of essential health benefits for any individual, in violation of final regulations established by HHS, the DOL and the Treasury? [45 CFR §147.126]

Examiner Observations: Review of the policy plans determined that no lifetime or annual limits are applied to benefits. A review of claims samples found no lifetime/annual limits applied. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table F.8.a Results: Paid Claims Sample

Type	Total Population	Paid Sample	Pass	Fail	Standard	Compliance
General Claims	17,115,153	26	26	0	93%	100%
Emergency Services	134,824	25	25	0	93%	100%
Rehabilitative/Habilitative Services	9024	25	25	0	93%	100%
Preventive/Wellness Services	85	85	85	0	93%	100%

Type	Total Population	Paid Sample	Pass	Fail	Standard	Compliance
Prescription Drugs/Pharmacy	1,620,548	25	25	0	93%	100%
Mental Health/Substance Abuse Services	26,925	25	25	0	93%	100%
Pediatric Services	17	17	17	0	93%	100%
Laboratory Services	40,826	25	25	0	93%	100%
Pregnancy/Maternity/Newborn Care	12,760	25	25	0	93%	100%
Clinical Trials	4	4	4	0	93%	100%
WHCRA	677	25	25	0	93%	100%
TOTAL	18,960,843	307	307	0	93%	100%

Table F.8.b Results: Denied Claims Sample

Type	Total Population	Denied Sample	Pass	Fail	Standard	Compliance
General Claims	235,210	50	50	0	93%	100%
Emergency Services	48,202	50	50	0	93%	100%
Rehabilitative/Habilitative Services	3	3	3	0	93%	100%
Preventive/Wellness Services	24	24	24	0	93%	100%
Prescription Drugs/Pharmacy	24,397	25	25	0	93%	100%
Mental Health/Substance Abuse Services	6,483	50	50	0	93%	100%
Pediatric Services	15	15	15	0	93%	100%
Laboratory Services	16,121	50	50	0	93%	100%
Pregnancy/Maternity/Newborn Care	82,636	50	50	0	93%	100%
Clinical Trials	5	5	5	0	93%	100%
WHCRA	1	1	1	0	93%	100%
TOTAL	413,097	323	323	0	93%	100%

Standard F.9: A health carrier may not deny benefits under a policy to any insured under the age of 19 pursuant to the provisions of any preexisting condition exclusion or other preexisting condition limitation. (2015 NAIC *Market Regulation Handbook*, Chapter 20A, §G, Standard 2)

Test Methodology:

- Do the Company grievance/complaint records identify inquiries regarding denial of benefits to insureds under 19 years of age on the basis of a preexisting condition? [45 CFR §147.108]
- Does the Company take appropriate corrective action/adjustments regarding the removal of the limitations/exclusions in a timely and accurate manner when a health carrier has improperly applied limitations or exclusions of coverage through the issuance of a preexisting condition exclusion on any individual under the age of 19? [45 CFR §147.108]

- Does the Company maintain proper documentation for all correspondence supporting corrective action provided to the insured, including website notifications? [W.Va. Code R. §114-15-4.2]

Examiner Observations: A review of claim samples identified no claims denied due to preexisting conditions which would have required corrective action. No exceptions were noted.
Examiner Recommendations: None

Results: Compliant

Table F.9 Results: Denied Claims Sample

Type	Total Population	Denied Sample	Pass	Fail	Standard	Compliance
General Claims	235,210	50	50	0	93%	100%
Emergency Services	48,202	50	50	0	93%	100%
Rehabilitative/Habilitative Services	3	3	3	0	93%	100%
Preventive/Wellness Services	24	24	24	0	93%	100%
Prescription Drugs/Pharmacy	24,397	25	25	0	93%	100%
Mental Health/Substance Abuse Services	6,483	50	50	0	93%	100%
Pediatric Services	15	15	15	0	93%	100%
Laboratory Services	16,121	50	50	0	93%	100%
Pregnancy/Maternity/Newborn Care	82,636	50	50	0	93%	100%
Clinical Trials	5	5	5	0	93%	100%
WHCRA	1	1	1	0	93%	100%
TOTAL	413,097	323	323	0	93%	100%

Standard F.10: A health carrier shall not impose cost sharing requirements upon preventive services, as defined in, and in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury). (2015 NAIC *Market Regulation Handbook*, Chapter 20A, §H, Standard 1)
Test Methodology:

- Does the Company take appropriate corrective action/adjustments on the insured's policy deductibles, copayments, coinsurance and other cost-sharing mechanisms in a timely and accurate manner when improper assessment of cost-sharing upon insureds occurs? [45 CFR §147.130]
- Does the Company maintain proper documentation for all correspondence supporting corrective action provided to the insured, including website notifications? [W.Va. Code R. §114-15-4.2]
- Do the Company's enrollment materials, marketing and sales materials, and other information disseminated to applicants/proposed insureds, insureds and claimants provide

complete and accurate information about the restriction of cost-sharing methods the health carrier may impose on the insured for preventive items and services described in the final regulations established by HHS, the DOL and the Treasury? [W.Va. Code §33-11-4 and 45 CFR §155.225]

- Does the Company properly apply deductibles, co-payments, coinsurance and other methods of cost-sharing on preventive items and services, in accordance with final regulations established by HHS, the DOL and the Treasury? [45 CFR §147.130]

Examiner Observations: Claim samples were reviewed to verify that cost sharing was not imposed on preventive services performed in-network. Enrollment materials and marketing materials were reviewed and found to provide complete and accurate information regarding the restrictions on the application of cost sharing on preventive services. No exceptions were noted.

Note: The paid sample size for this standard was determined by extraction of all CPT codes for "preventive service" that had a copayment, coinsurance, and/or deductible applied. The sample resulted in eighty-five (85) paid claims, that when reviewed were determined to be wellness exams that were paid in addition to the "preventive service"; however, those services were determined to be not recommended per the USPSTF (US Preventive Services Task Force), not on the CDC's (Center for Disease Control) immunization schedule, or were billed by a hospital and not part of the wellness examination.

Examiner Recommendations: None

Results: Compliant

Table F.10.a Results: Preventive Services Paid Claims Sample

Type	Total Population	Paid Sample	Pass	Fail	Standard	Compliance
Preventive/Wellness Services	85	85	85	0	93%	100%

Table F.10.b Results: Clinical Trials Denied Claims Sample

Type	Total Population	Denied Sample	Pass	Fail	Standard	Compliance
Preventive/Wellness Services	24	24	24	0	93%	100%

G. COMPLAINTS/GRIEVANCES/APPEALS

Evaluations of the standards in the Company's complaint handling business area are based on Company responses to various information requests and the review of compliant files at the Company. Complaints reviewed included "direct" consumer complaints and complaints received from the Office of the Insurance Commissioner. There are competing regulatory and statutory requirements for Health Entities regarding complaints grievances the definition of a complaint is, "...any written communication primarily expressing a grievance." HMO's are not subject to W. Va. Code §33-11-4 (Unfair Trade Practices Act) and therefore no specific regulatory or statutory timeframes responses to complaints received at the Offices of the Insurance Commissioner; however the WVOIC Consumer Services Division has adopted a fifteen (15) working day timeframe for responses to its office. For the purposes of this report Standards G1 through G4 are applied only to complaints or grievances reported directly to the WVOIC.

W. Va. Code §33-25A-12 requires HMOs to "establish and maintain a grievance procedure, which has been approved by the commissioner, to provide adequate and reasonable procedures for the expeditious resolution of written grievances initiated by enrollees concerning any matter relating to any provisions of the organization's health maintenance contracts, including, but not limited to, claims regarding the scope of coverage for health care services; denials, cancellations or non-renewals of enrollee coverage; observance of an enrollee's rights as a patient; and quality of the health care services rendered". W. Va. Code R. §114-96-1 et seq. provides specific guidance for all "issuers" or Health Benefit Plans with regard to the "establishment and maintenance of procedure by issuers to assure all covered persons have the opportunity for the appropriate resolution of grievances." W. Va. Code R. §114-96-2.17 defines a grievance as:

> *2.17. "Grievance" means a written complaint or, if the complaint involves an urgent care request submitted by or on behalf of a covered person, an oral complaint, regarding:*
>
> *2.17. a. Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;*
>
> *2.17. b. Claims payment, handling or reimbursement for health care services; or*
>
> *2.17. c. Matters pertaining to the contractual relationship between a covered person and an issuer.*

W. Va. Code R. §§114-96-4 & 5 outlines specific procedures for resolution grievances which involve adverse determination otherwise known as "appeals". which are addressed in Standards G5, G6, G7, G8, G9 and G10. Compliance issues were determined based on both federal and state statutes and rules related to internal appeals specifically 45 CFR §§147.136 and 156.1010(b) and W.Va. Code R. §§114-96-4 and 5.

Internal complaints or "Grievances not involving adverse determination" are subject to W. Va. Code R. §114-96-6 and are covered in Standards G6, G9, G10, and G11.

Standard G.1: All complaints are recorded in the required format on the regulated entity's complaint register. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §B, Standard 1)

Test Methodology:

- Does the Company record and maintain a complaint register with all required information? [W.Va. Code R. §§114-15-4.6 and 114-96

Examiner Observations: The Company records and maintains a complaint register and a log of all complaints.

Examiner Recommendations: None

Results: Compliant

Table G.1 Results: Complaints Recorded Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
WVOIC Complaints	18	18	18	0	90%	100%

Standard G.2: The regulated entity has adequate complaint handling procedures in place and communicates such procedures to policyholders. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §B, Standard 2)

Test Methodology:

- Does the Company have complaint procedures in place to satisfactorily handle complaints received? [W.Va. Code §33-25A-12 and W. Va. Code R. §114-53]
- Does the Company provide a telephone number and address for consumer inquiries? [W.Va. Code §33-25A-12(b)(3)]

Examiner Observations: The examiners reviewed procedures and the Company has adequate procedures in place for the handling of complaints and grievances. The enrollment packet and policy forms were found to include a Company telephone number and address for consumer inquiries. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard G.3: The regulated entity takes adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules and regulations and contract language. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §B, Standard 3)

Test Methodology:

- Does the Company respond fully to the issues raised in all complaints? [W.Va. Code §33-25A-12]
- Does the Company adequately document all complaint files? [W.Va. Code R. §114-15-4]

Examiner Observations: A review of the WVOIC complaints and determined that all were satisfactorily resolved. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table G.3 Results: Complaints Finalized Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
WVOIC Complaints	18	18	18	0	90%	100%

Standard G.4: The time frame within which the regulated entity responds to complaints is in accordance with applicable statutes, rules and regulations. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §B, Standard 4)

Test Methodology:

- Does the Company respond timely, within twenty (20) working days, taking up to an additional 10 (ten) working days to issue a written decision , to the issues raised in all complaints? [W.Va. Code R. §114-96]

Examiner Observations: The examiners reviewed the WVOIC complaints and Company recorded complaints. No exceptions were noted.

Examiner Recommendations: The Company should review and amend its procedures to include the required timeframes for handling complaints.

Results: Compliant

Table G.4 Results: Complaint Timely Response Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
WVOIC Complaints	18	18	18	0	90%	100%

Standard G.5: A health carrier offering individual health insurance coverage shall maintain records of all claims and notices associated with the internal claims and appeals process for the length of time specified in the final regulations established by the U.S. Department of

Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury). (2015 NAIC *Market Regulation Handbook*, Chapter 20A, §C, Standard 1)

Test Methodology:

- Does the Company have established and implemented written policies and procedures regarding grievance records handling in accordance with final regulations established by HHS, the DOL and the Treasury? [W.Va. Code R. §114-96-4.2]
- Does the Company maintain and make available grievance records for at least six years for first level grievances involving an adverse determination and for expedited reviews of grievances involving an adverse determination? [W.Va. Code R. §114-96-3.1.b and 45 CFR §147.136(b)(3)(H)]

Examiner Observations: The examiners reviewed the Company's appeals and grievance policies and procedures to determine whether the Company was in compliance with all state statutes and regulations. The Company retention schedules were reviewed to ensure that the Company maintains grievance records for at least six (6) years. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard G.6: The health carrier shall comply with grievance procedures requirements, in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury). (2015 NAIC *Market Regulation Handbook*, Chapter 20A, §C, Standard 2)

Test Methodology:

- Does the Company have procedures for and conduct first level reviews of grievances involving an adverse determination to include a statement of a covered person's right to contact the insurance commissioner's office or ombudsman's office for assistance at any time, and include the telephone number and address of the insurance commissioner or ombudsman's office in compliance with applicable statutes, rules and regulations? [42 U.S.C. §300gg-19 and 45 CFR §147.136]
- Does the Company define "Grievance" as a written complaint or, if the complaint involves an urgent care request submitted by or on behalf of a covered person, an oral complaint? [W. Va. Code §33-25A-12 and W.Va. Code R. §114-96-2.17]
- Does the Company provide notice within 10 days after the independent reviewer rejects the grievance for the opportunity to resubmit under applicable state statutes, rules and regulations equivalent to the Health Carrier Grievance Procedure Model Act (#72)? [W.Va. Code R. §114-96-4.1]

Examiner Observations: The procedures were reviewed for the applicable language regarding the covered person's rights and contact information for the insurance commissioner's office or ombudsman's office for assistance. File review indicated one (1) file where a response to a grievance took fifty-one (51) days. The company agreed on the timeframe to respond, stating that the member had approved the additional time; however, code indicates the issuer "shall notify within...twenty working days..." and only for circumstance beyond the issuer's control "...may take up to an additional ten days to issue a written decision". This is a violation as it was the issuer's internal issue for the delay, as well as the code is clear on the timeframe for response.

Note: Required by code, acknowledgment letters are to be sent within three (3) working days upon receipt of a grievance. The Company's policy procedure for grievances did not show this step in the process; however, the Company does attempt to contact the member by telephone. The Company has agreed that going forward their policy procedures will include the acknowledgment letter within three (3) working days and letters will be sent.

Note: For the tables following the balance of this section, the Company has a two-step appeals process. Their definition of Appeal is a verbal or written contact made by a member or authorized person, provider or practitioner expressing dissatisfaction with or requesting a change of an adverse determination of services that have not been rendered yet or services that have member responsibility. This step is considered a "second review", the "informal appeal". If the member is not satisfied with the decision in this informal step the member can submit a written grievance, the "formal appeal". In addition, both the Appeals and Grievance populations below were derived from years 2015 and 2016. For the informal appeals, the examiners reviewed all ten (10) of the partially upheld and seventy-four (74) of the upheld for the total of eighty-for (84), in addition to the eighty-four (84) from the reversed appeals for the total sample size of one hundred sixty-eight (168). The entire Grievance population was reviewed.

Examiner Recommendations: The Company should ensure that grievance responses adhere to the required timeframes for response. The Company should also amend policy procedures for grievance to send acknowledgment letters within the required timeframes.

Results: Predominantly Compliant

Table G.6 Results: Grievance/Appeal Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Informal Appeals	391	168	168	0	90%	100%
Grievances involving adverse determination	28	28	27	1	90%	96%
Grievances not involving adverse determination	59	59	59	0	90%	100%
TOTAL	478	255	254	1	90%	99%

Standard G.7: The health carrier shall conduct first-level reviews of grievances involving an adverse determination in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

(2015 NAIC *Market Regulation Handbook*, Chapter 20A, §C, Standard 3)

Test Methodology:

- Does the Company ensure that the first level review is conducted in a manner to ensure the independence and impartiality of the individuals involved in making the review decision? [W.Va. Code R. §§114-95-.2.b and c and 5.3, and 45 CFR §147.136(b)(2)(ii)(D)]
- Does the Company provide the notice in a culturally and linguistically appropriate manner in accordance with federal regulations? [W.Va. Code R. §114-96-5.9 and 45 CFR §147.136(b)(2)(ii)(E)]
- Does the Company provide the notice as required in case of disenrollment or rescission, as included in the definition of adverse determination? [45 CFR §147.136(b)(3)(ii)(A)]

Examiner Observations: A sample of appeals and all grievance cases were reviewed for compliance. No exceptions.

Examiner Recommendations: None

Results: Compliant

Table G.7 Results: Grievance/Appeal Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Informal Appeals	391	168	168	0	90%	100%
Grievances involving adverse determination	28	28	28	0	90 %	100%
TOTAL	419	196	196	0	90%	100%

Standard G.8: The health carrier shall conduct expedited reviews of urgent care requests of grievances involving an adverse determination in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of labor (DOL) and the U.S. Department of the Treasury (Treasury).
(2015 NAIC *Market Regulation Handbook*, Chapter 20A, §C, Standard 4)

Test Methodology:

- Does the Company have established and implemented written policies and procedures regarding receiving and resolving expedited review of urgent care requests of grievances involving an adverse determination in accordance with final regulations established by HHS, the DOL and the Treasury? [W.Va. Code R. §114-96-7 and 45 CFR §147.136(b)(2)(ii)(A)]
- Does the Company provide the notice in a culturally and linguistically appropriate manner in accordance with federal regulations? [W.Va. Code R. §114-96-7.8.b and 45 CFR §147.136(b)(2)(ii)(E)]

Examiner Observations: The Company policies and procedures were reviewed for compliance. Sample appeal files were reviewed to determine compliance with the adverse determination notification requirement. No expedited reviews appeared in the sample.

Examiner Recommendations: None

Results: Compliant

Standard G.9: The health carrier documents, maintains and reports grievances and establishes and maintains grievance procedures in compliance with applicable statutes, rules and regulations. (2015 NAIC *Market Regulation Handbook*, Chapter 20, §H, Standard 2)

Test Methodology:

- Does the Company maintain a grievance register consisting of written records to document all first level and expedited grievances received during a calendar year (the register) in the format prescribed by law? [W.Va. Code §33-25A-12(b)(11) and W.Va. Code R. §114-96-3]
- Does the Company retain the grievance register compiled for a calendar year for the longer of three years or until the insurance commissioner has adopted a final report of an examination that contains a review of the grievance register for year,? [W.Va. Code R. §114-96-3 and 45 CFR 156.705]
- Does the Company submit to the insurance commissioner, at least annually, a report in the format specified by the insurance commissioner? [W.Va. Code §33-25A-12(e) and W.Va. Code R. §114-96-3.2 and W. Va. Informational Letter No. 100A]

Examiner Observations: The Company's complaint, grievance, and appeals registers were reviewed for the required content. The Company's records retention schedule was reviewed to verify compliance with the retention requirements. The examiners determined that the company did not submit the required annual report to the WVOIC for 2015.

Examiner Recommendations: The Company should ensure that the annual Grievance report to the WV Insurance Commissioner is sent as required in W.Va. Code R. §114-96-3.2.

Note: The Company indicated that a new employee had been assigned duties of the Appeal/Grievance Coordinator and this employee was unaware at the time of the requirement for the annual report. The Company provided the report for 2015 during the examination.

Results: Predominantly Compliant

Standard G10: A health carrier has implemented grievance procedures, disclosed the procedures to covered persons, in compliance with applicable statutes, rules and regulations,

and files with the commissioner a copy of its grievance procedures, including all forms used to process a grievance. (2015 NAIC *Market Regulation Handbook*, Chapter 20, §H, Standard 3)

Test Methodology:

- Has the Company filed with the insurance commissioner a copy of its grievance procedures required by applicable state statutes, rules and regulations regarding first level review of grievances involving an adverse determination, standard review of grievances not involving an adverse determination, and voluntary review of grievances from covered persons, or, if applicable, the covered person's authorized representative, including all forms used to process grievance requests? [W. Va. Code §33-25A-12 and W.Va. Code R. §114-96-4.2]
- Does the Company file annually with the insurance commissioner, as part of its annual grievance report required by applicable state statutes, rules and regulations, a certificate of compliance stating that the health carrier has established and maintains, for each of its health benefit plans, grievance procedures that fully comply with applicable state statutes, rules and regulations? [W.Va. Code R. §114-96-4.3]
- Does the Company include a description of its grievance procedures in or attached to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage provided to covered persons? [W.Va. Code §33-25A-12(b) and W.Va. Code R. §114-96-4.4]
- Do the Company grievance procedure documents include a statement of a covered person's right to contact the insurance commissioner's office for assistance at any time, and include the telephone number and address of the insurance commissioner's office? [W.Va. Code §33-25A-12(b)(7) and W.Va. Code R. §114-96-4.5]

Examiner Observations: The examiners verified that the Company provides the insurance commissioner a copy of the grievance procedures and a certificate of compliance annually, as well as verifying that the grievance procedures are included in the membership booklet provided to the covered persons. The grievance procedure documents include a statement of the covered person's right to contact the insurance commissioner's office for assistance. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard G.11: The health carrier has procedures for and conducts standard reviews of grievances not involving an adverse determination in compliance applicable statutes, rules and regulations. (2015 NAIC *Market Regulation Handbook*, Chapter 20, §H, Standard 5)

Test Methodology:

- Does the Company have established written procedures for standard review of grievances that do not involve an adverse determination, which permit the covered person to file a grievance with the health carrier, and which comply with applicable statutes and rules? [W.Va. Code R. §114-96-6.1 et seq.]
- Does the Company, within three working days from the date the grievance is received, inform the covered person of his or her right to submit written material for the person or persons designated by the health carrier to consider when conducting the review? [W.Va. Code R. §114-96-6.2.b]
- Does the Company notify in writing the covered person of the decision within 20 working days after the date of receipt of the request, for a standard review of a grievance? [W.Va. Code R. §114-96-6.4]
- Does the Company's written decision issued pursuant to a standard review of a grievance not involving an adverse determination contain all the required information pursuant to applicable statutes and rules? [W.Va. Code R. §114-96-6.5]

Examiner Observations: The examiners reviewed a population of fifty-nine (59) complaints, the entire list from 2015 and 2016, with five (5) complaints being duplicates. All of the complaints were results of telephone calls from the member to make the Company aware of an issue and as such, there was no regulatory requirement for the Company to respond in writing. In addition, in twenty-three (23) cases the member agreed to and the Company conducted an investigation further into the instance to ensure quality control, which the Company refers to as a "Quality Investigation". No exceptions were noted.

However, the Company complaint policy did not include the proper complaint response times as required by W. Va. Code R. §114-96-6. The Company policy stated "Complaints are attempted to be resolved within thirty days of receipt...but not to exceed forty-five days". In response to the RFI, the company indicated that the current timeframes included in their Complaint Policy were incorrect and would be amended to the correct timeframes.

Note: The "grievances" in the table below consist of direct consumer complaints received by the company, which the Company includes all complaints, verbal or written, and as such all are included all for record keeping purposes. These complaints are grievances without adverse determination. The grievance procedures were reviewed for the applicable language regarding the handling of grievances not involving adverse determination. A time study was performed on a sample of appeals to determine compliance with regulations. No exceptions were noted.

Examiner Recommendations: None

Results: Predominantly Compliant

Table G.11 Results: Grievance Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Grievances not involving adverse determination	59	59	59	0	90%	100%

H. NETWORK ADEQUACY

The evaluation of the business area related to the Company's network adequacy is based on Company responses to information requested by the examiner, discussions with company staff, and review of the Company geographic mapping by ZIP code of all providers including Essential Community Providers (ECPs). This portion of the examination is designed to test whether the Company has sufficient providers to cover all the medical and mental health needs of each of the members.

Standard H.1: The company demonstrates, using reasonable criteria, that it maintains a network that is sufficient in number and types of providers to ensure that all services to enrollees will be accessible without unreasonable delay. (2015 NAIC *Market Regulation Handbook*, Chapter 20, §I, Standard 1)

Test Methodology:

- Has the Company established and maintained adequate arrangements to ensure reasonable proximity of participating providers to the business or personal residences of enrollees? [W. Va. Code §33-25A-4, W. Va. Code R. §114-53-6, W.Va. Informational Letter 100A and 45 CFR §156.230]
- Does the Company monitor, on an ongoing basis, its providers, provider groups, and intermediaries with which it contracts, to ensure the ability, clinical capacity, financial capability and legal authority, including applicable licensure requirements, to furnish all contracted benefits to enrollees? [W. Va. Code §33-25A-4, W. Va. Code R. §114-53-6 and 45 CFR §156.340]

Examiner Observations: The Company's process for ensuring an adequate network was reviewed. It was determined that the Company has established and maintained adequate arrangements, and has a monitoring process in place to ensure all providers and provider groups have the ability, clinical capacity, financial capability and legal authority to furnish all contracted benefits to enrollees. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard H.2: The company ensures that enrollees have access to emergency services twenty-four (24) hours per day, seven (7) days per week within its network and provides coverage for urgently needed services and emergency services outside of the service area. (2015 NAIC *Market Regulation Handbook*, Chapter 20, §I, Standard 4)

Test Methodology:

- Does the Company operate or contract with facilities within the network to provide enrollees with access to emergency and urgently needed services on a twenty-four (24) hours per day, seven (7) day per week basis? [W. Va. Code §33-25A-8d and 45 CFR §147.138 and 45 CFR §156.230]
- Does the Company cover emergency services or services that are immediately required for an unforeseen illness, injury or condition, when it is not reasonable to obtain services through network providers with the cost sharing applied not greater than that applied to in-network providers? [W. Va. Code §33-25A-8d and 45 CFR §147.138 and 45 CFR §156.230]

Examiner Observations: The examiner reviewed all contracts with providers to ensure access to services was available to emergency and urgently needed services on a twenty-four (24) hours per day, seven (7) day per week basis, and that all emergency services are covered in full. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard H.3: The company provides at enrollment a provider directory that lists all providers who participate in its network. It also makes available, on a timely and reasonable basis, updates to its directory. (2016 NAIC *Market Regulation Handbook*, Chapter 20, §I, Standard 8)

Test Methodology:

- Does the Company provide at the time of enrollment a provider directory? [W. Va. Code §33-25A-4, W. Va. Code R. §114-53-6, W.Va. Informational Letter 100A and 45 CFR §156.230]
- Does the Company timely and reasonably updates its directory? [W. Va. Code §33-25A-4, W. Va. Code R. §114-53-6, W.Va. Informational Letter 100A , 45 CFR §147.138 and 45 CFR §156.230]

Examiner Observations: The Company's provider directory was reviewed and the website checked to ensure updated directories were available as required by law. No exceptions were noted.

Note: The examiner's review of the Company's online Provider Directory contained inconsistent information regarding the acceptance of new patients. For providers not taking new patients, under the section "Accepting New Patients" was indicated "Yes", but under the "Restrictions" section indicated "Accepting Existing Patients Only". The Company has agreed is currently confusing and changes will be made to correct the conflicting information.

Examiner Recommendations: The Company should ensure that the online Provider Directory is clear for members to be able to ascertain whether a provider is accepting new patients.

Results: Predominantly Compliant

I. QUALITY ASSESSMENT AND IMPROVEMENT

The evaluation of the business area related to the Company's quality assessment program is required by the ACA, and is based on Company responses to information requested by the examiner, discussions with company staff, and review of the Company's ongoing program to evaluate and assess the quality of health care provided to covered persons, and to provide oversight to its contracted entities. This portion of the examination is designed to test whether the Company has sufficient procedures and assessment tools in place to collect, analyze and respond to the needs of its members. Specifically, HMOs must adhere to W. Va. Code R. §114-53, which requires a health maintenance organization to have a quality assurance program with the goals of "...appropriate medical services delivered to members, while addressing quality of care; monitor, evaluate and improve the quality of health care; provide a systemic process that promotes the delivery of medically appropriate care in a timely, effective and efficient manner, while maintaining the quality of healthcare; direct members and providers toward the goal of quality, cost effective health care; and the quality assurance program shall include a mechanism for identifying potential utilization management issues and linking them to the HMO's utilization management program".

Standard I.1: The health carrier develops and maintains a quality assessment program in compliance with statutes, rules and regulations. (2015 NAIC *Market Regulation Handbook*, Chapter 20, §K, Standard 1)

Test Methodology:

- Does the Company have an established system designed to assess the quality of health care provided to covered persons, which includes a system for systematic collection, analysis and reporting of relevant data in accordance with statutory and regulatory requirements? [W. Va. Code R. §§114-53 and 114-51]

Examiner Observations: The Company Quality Assessment Program was reviewed. It was determined to include a system for the collection, analysis and reporting of relevant data in compliance with state and federal laws. No exceptions were noted.

Note: In November of 2015 the NCQA (National Committee for Quality Assurance issued the Company a rating for their Commercial-HMO product line as an accreditation status of "Commendable", which was effective November 12, 2015 and expires November 12, 2018.

Examiner Recommendations: None

Results: Compliant

Standard I.2: The company monitors the activities of the entity with which it contracts to perform quality assessment or quality improvement functions and ensures that the requirements of state law are met. (2015 NAIC *Market Regulation Handbook*, Chapter 20, §K, Standard 4)

Test Methodology:

- Does the Company have a policy to address effective methods of accomplishing oversight of each delegated activity? [W. Va. Code R. §§114-53-4.4 and 114-51]

Examiner Observations: The Company has a schedule for internal audits to monitor all entities with which it contracts to perform quality assessment or quality improvement function. No exceptions were noted. (See Also Company Operations/Management Standards A1, A5 and A6)

Examiner Recommendations: None

Results: Compliant

J. UTILIZATION MANAGEMENT

The evaluation of the standards related to the Company's utilization management program is based on the Company's responses to information requests from the examiner, discussions with company staff, and file sample reviews during the examination process. Included in the review were all requests for benefits or services, which required approval as part of the Company's utilization management program designed to control costs and provide for effective customer services. Compliance issues were determined based on both federal and state statutes and rules related to internal and external appeals as applied to ACA products, specifically W. Va. §§33-25A-17a & 33-25A-4(1)(b), W.Va. Code R. §114-95-1 et seq. and 45 CFR §147. ACL was utilized to select samples from the utilization management requests filed with the Company.

Standard J.1: The health carrier shall operate its utilization review program in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury). (2015 NAIC *Market Regulation Handbook*, Chapter 20A, §K, Standard 1)

Test Methodology:

- Does the Company have established and implemented written policies and procedures regarding the operation of its utilization review program, in accordance with final regulations established by HHS, the DOL and the Treasury? [W.Va. Code R. §§114-95-5 and 114-51-4.1]
- Does the Company ensure that the review is conducted in a manner to ensure the independence and impartiality of the individuals involved in making the utilization review

or benefit determination? [W. Va. Code R. §114-51-4.7 et seq. and 45 CFR §147.136(b)(3)(ii)(D)]

- Does the Company have procedures to ensure effective corporate oversight of its utilization review program? [W.Va. Code R. §§114-51-4.3, 114-51-4.4 and114-95-3]
- Does the Company annually certify in writing to the insurance commissioner that the utilization review program of the health carrier complies with all applicable state and federal laws establishing confidentiality and reporting requirements? [W.Va. Code R. §§114-51-4.2 et seq. and 114-95-10]
- Does the Company use documented clinical review criteria and ensure that qualified health care professionals administer the utilization review program and oversee review decisions, and that it appoints clinical peers to evaluate the clinical appropriateness of adverse determinations? [W.Va. Code R. §§114-51-4.7 et seq. and 114-95-5]
- Does the Company issue utilization review decisions and benefit determinations in a timely and efficient manner pursuant to the requirements set forth in applicable state statutes, rules and regulations? [W.Va. Code R. §§114-51-4.1, 114-51-4.8 et seq. and 114-95-7.1]

Examiner Observations: The examiner reviewed the Company's Utilization Management Program. Its procedures are in compliance with regulations and the reviews are conducted to ensure independence and impartiality of the individuals making the review. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard J.2: The health carrier shall provide written notice of an adverse determination of standard utilization review and benefit determinations, in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury). (2015 NAIC *Market Regulation Handbook*, Chapter 20A, §K, Standard 2)

Test Methodology:

- Does the Company provide the notice in a culturally and linguistically appropriate manner? [W.Va. Code R. §114-95-7.3.b and 45 CFR §147.136(b)(3)(ii)(E)]
- Does the Company, if the adverse determination is a rescission, provide the advance notice of the rescission determination required to be provided under applicable state statutes, rules and regulations related to the advance notice requirement of a proposed rescission? [45 CFR §147.128]
- Does the Company issue notification in writing or electronically of an adverse determination in a manner calculated to be understood by the covered person? [W.Va. Code R. §114-95-7.]

Examiner Observations: A sample of utilization requests were reviewed to determine if notification is provided in compliance with regulations. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table J.2 Results: Utilization Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Pre-Authorization Approved	10,894	25	25	0	90%	100%
Pre-Authorization Denied	972	25	25	0	90%	100%
Retrospective Denied	116	25	25	0	90%	100%
TOTAL	11,982	75	75	0	90%	100%

Standard J.3: The health carrier shall conduct expedited utilization review and benefit determinations, in a timely manner and in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury). (2015 NAIC *Market Regulation Handbook*, Chapter 20A, §K, Standard 3)

Test Methodology:

- Does the Company provide the notice in a culturally and linguistically appropriate manner? [W.Va. Code R. §114-95-7.3.b and 45 CFR §147.136(b)(3)(ii)(E)]
- Does the Company, if the adverse determination is a rescission, provide the advance notice of the rescission determination required to be provided under applicable state statutes, rules and regulations related to the advance notice requirement of a proposed rescission? [45 CFR §147.128 and 45 CFR §147.136(b)(3)(ii)(A)]
- Does the Company have established written procedures pursuant to applicable state statutes, rules and regulations for receiving benefit requests from covered persons of expedited utilization review and benefit determinations with respect to urgent care requests and concurrent review urgent care requests? [W.Va. Code R. §114-95-8 and 45 CFR §147.136]
- Does the Company, for an urgent care request, provide notice of the adverse determination, no later than 72 hours after the receipt of the request by the health carrier, in accordance with applicable state statutes, rules and regulations regarding procedures for expedited utilization review and benefit determination? [W.Va. Code R. §114-95-8 and 45 CFR §147.136]
- Does the Company make a determination for concurrent review urgent care requests involving a request by the covered person to extend the course of treatment beyond the initial period of time or the number of treatments, if the request is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments no more than 24 hours after the health carrier's receipt of the request? [45 CFR §147.136]
- Is the Company notification of an adverse determination pursuant to an expedited utilization review and benefit determination set forth in a manner calculated to be understood by the covered person, or, if applicable, the covered person's authorized representative? [45 CFR §147.136(b)(2)(ii)(E)]

Examiner Observations: A sample of utilization requests were reviewed to determine if notification is provided in compliance with regulations. No rescissions were found in the sample. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table J.3 Results: Utilization Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Pre-Authorization Approved	10,894	25	25	0	90%	100%
Pre-Authorization Denied	972	25	25	0	90%	100%
Retrospective Denied	116	25	25	0	90%	100%
TOTAL	11,982	75	75	0	90%	100%

Standard J.4: The health carrier shall conduct utilization reviews or makes benefit determinations for emergency services in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).
(2015 NAIC *Market Regulation Handbook*, Chapter 20A, §K, Standard 4)

Test Methodology:

- Does the Company provide benefits for services in an emergency department of a hospital that follows provisions set forth in applicable statutes, rules and regulations? [W.Va. Code R. §114-95-9]
- Does the Company provide in-network emergency services subject to applicable copayments, coinsurance, and deductibles? [W.Va. Code R. §114-95-9.3]
- Does the Company provide out-of-network emergency services with cost-sharing requirements that do not exceed the cost-sharing requirement imposed with respect to a covered person if the services were provided in-network? [W.Va. Code R. §114-95-9]

Examiner Observations: A sample of utilization requests were reviewed for compliance with emergency service benefits. All cost sharing requirements were imposed the same for out-of-network providers as for in-network providers. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table J.4 Results: Utilization Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Pre-Authorization Approved	10,894	25	25	0	90%	100%
Pre-Authorization Denied	972	25	25	0	90%	100%
Retrospective Denied	116	25	25	0	90%	100%
TOTAL	11,982	75	75	0	90%	100%

Standard J.5: The health carrier discloses information about its utilization review and benefit determination procedures to covered persons, or, if applicable, the covered person's authorized representative, in compliance with applicable statutes, rules and regulations. (2015 NAIC *Market Regulation Handbook*, Chapter 20, §L, Standard 3)

Test Methodology:

- Does the Company provide a clear and accurate summary of its utilization review and benefit determination procedures to covered persons, or, if applicable, to the covered person's authorized representative? [W.Va. Code R. §114-95-11]
- Does the Company provide a clear and comprehensive description of its utilization review procedures, including the procedures for obtaining adverse review determinations, and a statement of rights and responsibilities of covered persons, or, if applicable, the covered person's authorized representative, with respect to those procedures, in the certificate of coverage or member handbook provided to covered persons? [W.Va. Code R. §114-95-11]
- Does the Company print on its membership cards a toll-free telephone number to call for utilization review and benefit determination decisions? [W.Va. Code R. §114-95-11]

Examiner Observations: A review of the utilization program determined that the Company provides to covered persons a clear and accurate summary of its utilization review and benefit determination procedures, including procedures for obtaining adverse review determinations, and a statement of rights and responsibilities. The Company prints a toll-free telephone number on its membership cards. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard J.6: The health carrier makes standard utilization review and benefit determinations in a timely manner and as required by applicable state statutes, rules and regulations, as well as the provisions of HIPAA. (2015 NAIC *Market Regulation Handbook*, Chapter 20, §L, Standard 4)

Test Methodology:

- Does the Company, for prospective review determination, make the determination and notify the covered person no later than 15 days after the date the health carrier receives the request? [W.Va. Code R. §114-95-7]
- Does the Company make the notification of the adverse determination in accordance with state statutes, rules and regulations regarding procedures for standard utilization review and benefit determination? [W.Va. Code R. §114-95-7]
- Does the Company continue the health care service or treatment that is the subject of the adverse determination without liability to the covered person with respect to the internal review request made pursuant to state statutes, rules and regulations equivalent to the Health Carrier Grievance Procedure Model Act (#72)? [W.Va. Code R. §114-95-7]

- Does the Company, for retrospective review determinations, make the determination no later than 30 working days after the date of receiving the benefit request? [W.Va. Code R. §114-95-7]
- Does the Company make the notification of the adverse determination for retrospective review determinations in accordance with state statutes, rules and regulations regarding procedures for standard utilization review and benefit determination? [W.Va. Code R. §114-95-7]

Examiner Observations: A review and time study of utilization requests was performed to determine compliance with the notification requirements, as well as to determine compliance with laws and regulations regarding adverse determination continued treatment requirements.

Examiner Recommendations: None

Results: Compliant

Table J.6 Results: Utilization Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Pre-Authorization Approved	10,894	25	25	0	90%	100%
Pre-Authorization Denied	972	25	25	0	90%	100%
Retrospective Denied	116	25	25	0	90%	100%
TOTAL	11,982	75	75	0	90%	100%

Standard J.7: The health carrier monitors the activities of the utilization review organization or entity with which the carrier contracts and ensures that the contracting organization complies with a applicable state provisions equivalent to the Utilization Review and Benefit Determination Model Act (#73) and accompanying regulations. (2015 NAIC *Market Regulation Handbook*, Chapter 20, §L, Standard 7)

Test Methodology:

- Does the Company maintain adequate oversight of any delegated entities? [W.Va. Code R. §114-95-3]
- Does the Company have policies and procedures in place that ensure the utilization review programs of designees comply with all applicable state and federal laws establishing confidentiality and reporting requirements? [W.Va. Code R. §114-95-5]
- Does the Company annually certify in writing to the insurance commissioner that the utilization review program of its designee complies with all applicable state and federal laws establishing confidentiality and reporting requirements? [W.Va. Code R. §114-95-10]

Examiner Observations: The examiner reviewed the Company's Utilization Management Program. The program has all components required by statute. The examiner verified the Company annually certifies in writing to the insurance commissioner that the program is in compliance. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

K. EXTERNAL REVIEW

The evaluation of the standards related to the Company's external review process is based on the Company's responses to information requests from the examiner, discussions with company staff, and file sample reviews during the examination process. Included in the review were all appeal requests for external review, for which all internal appeals were exhausted. Compliance issues were determined based on both federal and state statutes and rules related to internal and external appeals as applied to QHP products, specifically 45 CFR §147.136 and W.Va. Code §114-97-4 et seq. All external appeals were reviewed.

Standard K.1: Companies covered under the NAIC Health Carrier External Review Model Act will be in compliance with the following procedures and criteria as well as with other applicable statutes, rules and regulations. (2015 NAIC *Market Regulation Handbook*, Chapter 20, §M, Standard 1)

Test Methodology:

- Does the Company notify covered persons in writing of the right to request an external review and include notice of the Company's responsibilities? [45 CFR §147.136]
- Does the Company provide the review procedures in or attached to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage? [W.Va. Code R. §114-97-14]
- Does the Company maintain written records in the aggregate and for each type of health benefit plan offered by the health carrier on all requests for external review? [W.Va. Code R. §114-96-3]

Examiner Observations: There were no external reviews during the examination period.

Note: During examiner review of the Company's external review procedures, it was noted that the wording utilized read as if the Company would assign an IRO (Independent Review Organization); however, code requires that the request for the external review be forwarded to the WVOIC for assignment of the IRO. Additionally, the procedure indicated that the IRO would provide the written decision within thirty (30) days and the correct amount of days is forty-five (45) days. The Company responded that this information would be corrected in their procedures.

Examiner Recommendations: The Company should correct their procedures for external review to adhere to proper language and timeframes required.

Results: Predominantly Compliant

Standard K.2: In jurisdictions that choose the Option 1 or Option 2 under the NAIC Health Carrier External Review Model Act for providing an external review process, companies will be in compliance with the following requirements, whether the request for the review is for a standard, expedited, or experimental/investigational review. (2015 NAIC *Market Regulation Handbook*, Chapter 20, §M, Standard 2)

Test Methodology:

- Does the Company comply with the external review process requirements for a standard, expedited, or experimental/investigational review? [W.Va. Code R. §§114-97-6, 7 and 8 and 45 CFR §147.136]

Examiner Observations: Since the advent of W. Va. Code R. §114-97, there were no external reviews requested.

Examiner Recommendations: None

Results: Unable to review

SUMMARY OF RECOMMENDATIONS

Standard A7 - It is recommended the Company ensure compliance in that policy records include the application with a legible means by which an examiner can identify the producer involved in the transaction.

Note: The Company agreed and indicated that the writing producer information will be captured going forward.

Standard G4 - It is recommended that the Company complaint policy include the proper complaint response times as required by W. Va. Code R. §114-96-6.

Note: The Company indicated that the current timeframes included in their Complaint Policy were incorrect and would be amended to the correct timeframes.

Standard G6 - It is recommended the Company ensure that acknowledgment letters are sent within three (3) working days upon receipt of a grievance.

Note: The Company has agreed that going forward their policy procedures will include the acknowledgment letter within three (3) working days and letters will be sent.

Standard G9 – It is recommended the Company ensure that the annual Grievance report to the WV Insurance Commissioner be sent as required in W.Va. Code R. §114-96-3.2.

Note: The Company indicated that a new employee had been assigned duties of the Appeal/Grievance Coordinator and this employee was unaware at the time of the requirement for the annual report. The Company provided the report for 2015 during the examination.

Standard H3 - It is recommended the Company ensure that their online Provider Directory contain consistent information regarding the acceptance of new patients.

Note: The Company has agreed is currently confusing and changes will be made to correct the conflicting information.

Standard K1 – It is recommended the Company ensure that their external review procedures, use the correct description of an IRO assignment from the WVOIC, as well as the procedure correctly indicating that the IRO would provide the written decision within the correct timeframe of forty-five (45) days.

Note: The Company responded that this information would be corrected in their procedures.

EXAMINER'S SIGNATURE AND ACKNOWLEDGEMENT

The examiner would like to acknowledge the cooperation and assistance extended by the Company during the course of the examination, in particular Carol Mamone, Sales Coordinator.

In addition to the undersigned, Mark Hooker, CIE, CPCU, CLMI, PIR, AMCM, CWCP, CCP, AIRC, PAHM, John Stike, CIE, CPCU, MCM, CWCP, CIPA, AU, APA, AFI, Desiree Mauller, AIE, CWCP, MCM, and Letha Tate, MCM all with the West Virginia Offices of the Insurance Commissioner also participated in this examination.

Barbara A. Hudson

Barbara A. Hudson, AIE, MCM, CWCP, PAHM
Examiner-in-Charge

EXAMINER'S AFFIDAVIT

State of West Virginia

County of Kanawha

EXAMINER'S AFFIDAVIT AS TO STANDARDS AND PROCEDURES USED IN AN EXAMINATION

I, Barbara A. Hudson, being duly sworn, states as follows:

1. I have the authority to represent West Virginia in the examination of The Health Plan of the Upper Ohio Valley Inc.

2. I have reviewed the examination work papers and examination report, and the examination of The Health Plan of the Upper Ohio Valley Inc. was performed in a manner consistent with the standards and procedures required by West Virginia.

The affiant says nothing further.

Barbara A. Hudson

Barbara A. Hudson, AIE, MCM, CWCP, PAHM
Examiner-in-Charge

Subscribed and sworn before me by Barbara A. Hudson on this 19th day of January 2017.

Georgia Lea Cisco

Notary Public

My commission expires: 10-11-2019